National health data dictionary version 15

Data elements

Accrued mental health care days

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—accrued mental health care days, total N[N(7)]
METeOR identifier:	286770
Registration status:	Health, Standard 08/12/2004
Definition:	The total number of accrued mental health care days provided by admitted patient care services and residential mental health care services within the reference period (from 1 July to 30 June inclusive).
Data Element Concept:	Establishment—accrued mental health care days

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N(7)]
Maximum character length:	8
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:

The days to be counted are only those days occurring within the reference period, i.e. from 1 July to the following 30 June for the relevant period, even if the patient/resident was admitted prior to the reference period or discharged after the reference period.

A day is measured from midnight to 2359 hours.

The following basic rules are used to calculate the number of accrued mental health care days:

- Admission and discharge on the same day is equal to one mental health care day.
- For a patient/resident admitted and discharged on different days all days are counted as mental health care days, except the day of discharge and any leave days.
- If the patient/resident remains in hospital or residential care facility from midnight to 2359 hours count as a mental health care day.
- The day a patient/resident goes on leave is not counted as a mental health care day, unless this was also the admission day.

- The day the patient/resident returns from leave is counted as a mental health care day, unless the patient/resident goes on leave again on the same day of return or is discharged.
- Leave days involving an overnight absence are not counted as mental health care days.
- If a patient/resident goes on leave the day they are admitted and does not return from leave until the day they are discharged, count as one mental health care day.
- If the patient/resident remains in a hospital or residential care facility from 1 July to 30 June (the whole of the reference period) count as 365 days (or 366 days in a leap year).
- If the patient/resident remains in a hospital or residential care facility after the end of the reference period (i.e. after 30 June) do not count any days after the end of the reference period.

The following additional rules cover special circumstances and in such cases, override the basic rules:

When calculating accrued mental health care days for the reference period:

- Count the mental health care days of those patients/residents separated during the reference period. Exclude any days that may have occurred before the beginning of the reference period.
- Count the mental health care days of those patients/residents admitted during the reference period who did not separate until the following reference period. Exclude the days after the end of the reference period.
- For patients/residents admitted before the reference period and who remain in after the reference period (i.e. after 30 June), count the mental health care days within the reference period only. Exclude all days before and after the reference period.

Examples of mental health care day counting for a reference period 1 July 2004 to 30 June 2005:

Patient/resident A was admitted to hospital on 4 June 2004 and separated on 6 July 2004. If no leave or transfer occurred counting starts on 1 July. Count would be 5 days as day of discharge is not counted.

Patient/resident B was admitted to hospital on 1 August 2004 and separated on 8 August 2004. If no leave or transfer occurred counting starts on 1 August. Count would be 7 days as day of discharge is not counted.

Patient/resident C was admitted to hospital on 1 June 2005 and separated on 6 July 2005. If no leave or transfer occurred counting starts on 1 June. Count would be 30 days as patient/resident was not discharged on 30 June, so every day up to and including 30 June would be counted.

Patient/resident D was admitted to hospital on 1 August 2003 and has remained continuously in hospital to the present time. If no leave or transfer occurred counting starts on 1 July 2004 and concludes on 30 June 2005. Count would be 365 days as there is no day of discharge.

Collection methods:

To be reported for admitted patient care services, including services that are staffed for less than 24 hours, and non-government organisation services where included.

NOTE: These data need to be disaggregated by Specialised mental health service setting (excluding Ambulatory care settings). For admitted patient care settings these counts also need to be disaggregated by Specialised mental health service program type and Specialised mental health service target population.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Activity and participation life area

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—activity and participation life area, code (ICF 2001) AN[NNN]
METeOR identifier:	320125
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The life area in which a person participates or undertakes activities, as represented by a code.
Context:	Human functioning and disability
Data Element Concept:	Person—activity and participation life area

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Functioning, Disability and Health 2001
Representation class:	Code
Data type:	String
Format:	AN[NNN]
Maximum character length:	5

Collection and usage attributes

Guide for use:

This metadata item contributes to the definition of the concept '**Disability**' and gives an indication of the experience of disability for a person.

The activities and participation codes are a neutral list that covers the full range of life areas in which a person can be involved. The domains can be used to record positive or neutral experience of functioning as well as limitations and restrictions.

Data can be collected at the three digit level in one chapter and at the chapter level in another. However it is only possible to collect data at a single level of the hierarchy in a single chapter to maintain mutual exclusivity. For example, it is not permitted to collect both 'Self care' (chapter level) and 'Looking after one's health' (3 digit level) as the former includes the latter.

The value domain below refers to the highest hierarchical level (ICF chapter level). Data collected at this level, in association with respective qualifiers (Activity difficulty level, Activity Need for assistance, Participation extent and Participation satisfaction level) will use the codes as indicated.

CODE d1 Learning and applying knowledge
CODE d2 General tasks and demands
CODE d3 Communication
CODE d4 Mobility

CODE d5 Self-care
CODE d6 Domestic life
CODE d7 Interpersonal interactions and relationships
CODE d8 Major life areas
CODE d9 Community, social and civic life

Data collected at this level will provide a general description of functioning for the person and can only be compared with data collected at the same level.

Each chapter contains categories at different levels ordered from general to detailed. For specific more detailed information the user should follow the structure of the ICF; the codes should be drawn from the same hierarchical level within any particular chapter. The full range of permissible values is listed in the **Activities** and **Participation** component of the ICF.

An example of a value domain at the 3 digit level from the Self-care chapter may include:
CODE d510 Washing oneself
CODE d520 Caring for body parts
CODE d530 Toileting
CODE d540 Dressing
CODE d550 Eating
CODE d560 Drinking
CODE d570 Looking after one's health

An example of value domains at the 4 digit level from the Mobility chapter may include:

CODE d4600 Moving around within the home
CODE d4601 Moving around within buildings other than home
CODE d4602 Moving around outside the home and other buildings
CODE d4701 Using private motorized transportation
CODE d4702 Using public motorized transportation

The prefix ***d*** denotes the domains within the component of *Activities and Participation*. At the user's discretion, the prefix ***d*** can be replaced by ***a*** or ***p***, to denote activities or participation respectively.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin: WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents: Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website http://www.who.int/classifications/icf/en/

- Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.cfm

Data element attributes

Collection and usage attributes

Guide for use:

This metadata item, in conjunction with Activity difficulty level code N, enables the provision of information about the presence and extent of activity limitation for any given life area; with Activity need for assistance code N, the provision of information about the need for assistance with the given life area.

The extent of, and level of satisfaction with, participation in a given area are indicated by the use of this metadata item with the qualifiers Participation extent code N and Participation satisfaction level code N.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references:

See also Person—need for assistance with activities in a life area, code N Health, Standard 29/11/2006, Community services, Standard 16/10/2006

See also Person—level of difficulty with activities in life areas, code (ICF 2001) N Health, Standard 29/11/2006, Community services, Standard 16/10/2006

See also Person—extent of participation in a life area, code (ICF 2001) N Health, Standard 29/11/2006, Community services, Standard 16/10/2006

See also Person—level of satisfaction with participation in a life area, code N Health, Standard 29/11/2006, Community services, Standard 16/10/2006

Implementation in Data Set Specifications:

Activities and Participation cluster Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Activity when injured

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—activity type, code (ICD-10-AM 7th edn) ANNNN
METeOR identifier:	391320
Registration status:	Health, Standard 22/12/2009
Definition:	The type of activity being undertaken by the person when injured, as represented by a code.
Data Element Concept:	Injury event—activity type

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition
Representation class:	Code
Data type:	String
Format:	ANNNN
Maximum character length:	5

Data element attributes

Collection and usage attributes

Guide for use:	Admitted patient: External cause codes V00 to Y34 must be accompanied by an activity code.
Comments:	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 term is the basis for identifying work-related and sport-related injuries.

Source and reference attributes

Origin:	National Centre for Classification in Health National Injury Surveillance Unit

Relational attributes

Related metadata references:	Supersedes Injury event—activity type, code (ICD-10-AM 6th edn) ANNNN Health, Superseded 22/12/2009
Implementation in Data Set Specifications:	Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009 *Implementation start date:* 01/07/2010 Injury surveillance DSS Health, Standard 14/12/2009

Activity when injured (non-admitted patient)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—activity type, non-admitted patient code N[N]
METeOR identifier:	268942
Registration status:	Health, Standard 01/03/2005
Definition:	The type of activity undertaken by the non-admitted patient when injured, as represented by a code.
Data Element Concept:	Injury event—activity type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
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
6	Unspecified activities

Collection and usage attributes

Guide for use: 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.

Data element attributes

Collection and usage attributes

Comments: 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.

Source and reference attributes

Origin: National Centre for Classification in Health

National Injury Surveillance Unit

Relational attributes

Related metadata references: Supersedes Activity when injured, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.7 KB)

Implementation in Data Set Specifications:

Injury surveillance DSS Health, Superseded 05/02/2008

Injury surveillance DSS Health, Superseded 14/12/2009

Injury surveillance DSS Health, Standard 14/12/2009

Injury surveillance NMDS Health, Superseded 03/05/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Injury surveillance NMDS Health, Superseded 07/12/2005

Actual place of birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—setting of birth (actual), code N
METeOR identifier:	269937
Registration status:	Health, Standard 01/03/2005
Definition:	The actual place where the birth occurred, as represented by a code.
Context:	Perinatal statistics
Data Element Concept:	Birth event—setting of birth

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values: / *Supplementary values:*

Value	Meaning
1	Hospital, excluding birth centre
2	Birth centre, attached to hospital
3	Birth centre, free standing
4	Home
8	Other
9	Not stated

Collection and usage attributes

Comments:	The development of a definition of a birth centre is currently under consideration by the Commonwealth in conjunction with the states and territories.

Data element attributes

Collection and usage attributes

Guide for use:

This is to be recorded for each baby the mother delivers from this pregnancy.

CODE 4 Home

Should be reserved for those births that occur at the home intended.

CODE 8 Other

Used 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'.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Actual place of birth, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.0 KB)

Implementation in Data Set Specifications:

Perinatal NMDS Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Perinatal NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Perinatal NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Acute coronary syndrome procedure type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—acute coronary syndrome procedure type, code NN
METeOR identifier:	356659
Registration status:	Health, Standard 01/10/2008
Definition:	The type of procedure performed, that is pertinent to the treatment of acute coronary syndrome, as represented by a code.
Data Element Concept:	Person—acute coronary syndrome procedure type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Coronary artery bypass graft (CABG)
05	Reperfusion: fibrinolytic therapy
06	Reperfusion: primary percutaneous coronary intervention (PCI)
07	Reperfusion: rescue percutaneous coronary intervention (PCI)
08	Vascular reconstruction, bypass surgery, or percutaneous intervention to the extremities or for aortic aneurysm
09	Amputation for arterial vascular insufficiency
10	Diagnostic cardiac catheterisation/angiography
11	Blood transfusion
12	Insertion of pacemaker
13	Implantable cardiac defibrillator
14	Intra-aortic balloon pump (IABP)
15	Non-invasive ventilation (CPAP)
16	Invasive ventilation
17	Defibrillation
18	Revascularisation: percutaneous coronary intervention (PCI)
19	Pulmonary artery (Swan Ganz) catheter
88	Other

Supplementary values:

99	Not stated/inadequately described

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:

More than one procedure can be recorded. Record all codes that apply.

Codes '88' and '99' in combination cannot be used in multiple entries.

CODE 06 Reperfusion: primary percutaneous coronary intervention (PCI)

Primary PCI relates to balloon angioplasty and/or stent implantation for reperfusion therapy of a ST-segment-elevation myocardial infarction (STEMI).

CODE 07 Reperfusion: rescue percutaneous coronary intervention (PCI)

Rescue PCI relates to a balloon angioplasty and/or stent implantation that is performed following failed fibrinolysis in people with continuing or recurrent myocardial ischaemia.

CODE 18 Revascularisation: percutaneous coronary intervention (PCI)

Revascularisation PCI relates to the restoration of blood flow through balloon angioplasty and/or stent implantation outside the setting of myocardial salvage for STEMI. Revascularisation PCI may be performed on a person following STEMI where there is objective evidence of spontaneous or inducible ischaemia or hameodynamic instability. Revascularisation PCI may also be performed on a person with high-risk non-ST-segment-elevation acute coronary syndrome.

When read in conjunction with Person—clinical procedure timing, code N, this metadata item provides information on the procedure(s) provided to a patient prior to or during this presentation.

When read in conjunction with Person—acute coronary syndrome risk stratum, code N, codes 01, 05, 06, 07, 08, 09, 10 and 18 of this metadata item provide information for risk stratification.

Where codes 06, 07 and 18 have been recorded please also record Person - percutaneous coronary intervention procedure, code N.

Collection methods:

For each Person-acute coronary syndrome procedure type, code NN, the following timing data elements must also be recorded, where applicable:

- Person - clinical procedure timing, code N
- Person - intravenous fibrinolytic therapy date, DDMMYYYY
- Person - intravenous fibrinolytic therapy time, hhmm

- Person - primary percutaneous coronary intervention date, DDMMYYYY
- Person - primary percutaneous coronary intervention time, hhmm
- Person - rescue percutaneous coronary intervention date, DDMMYYYY
- Person - rescue percutaneous coronary intervention time, hhmm
- Person - revascularisation percutaneous coronary intervention date, DDMMYYYY
- Person - revascularisation percutaneous coronary intervention time, hhmm
- Person - pacemaker insertion date, DDMMYYYY
- Person - pacemaker insertion time, hhmm
- Person - implantable cardiac defibrillator procedure date, DDMMYYYY
- Person - implantable cardiac defibrillator procedure time, hhmm
- Person - intra-aortic balloon pump procedure date, DDMMYYYY
- Person - intra-aortic balloon pump procedure time, hhmm
- Person - non-invasive ventilation administration date, DDMMYYYY
- Person - non-invasive ventilation administration time, hhmm

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Person—acute coronary syndrome procedure type, code NN Health, Superseded 01/10/2008
	See also Person—clinical procedure timing, code N Health, Standard 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Acute coronary syndrome related clinical event type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with acute coronary syndrome—type of acute coronary syndrome related clinical event experienced, code N[N]
METeOR identifier:	338314
Registration status:	Health, Standard 01/10/2008
Definition:	The type of acute coronary syndrome related clinical event, as represented by a code.
Data Element Concept:	Person with acute coronary syndrome—type of acute coronary syndrome related clinical event

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	Cardiogenic shock
2	Cardiac rupture
3	Cardiac arrest
4	New or recurrent myocardial infarction
5	Stroke
6	Acute pulmonary oedema
7	Recurrent rest angina with electrocardiogram changes
8	Recurrent rest angina without electrocardiogram changes
9	New onset arrhythmia: atrial
10	New onset arrhythmia: ventricular
11	New onset arrhythmia: heart block (1,2,3)
12	Unplanned revascularisation
13	Acute renal failure
14	Thrombocytopaenia

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Cardiogenic shock

Use this code when the person has experienced cardiogenic shock, including if the person was in shock at the time of presentation to the hospital.

Cardiogenic shock is defined as:

- hypotension (systolic BP <90mmHg for at least 30 minutes or the need for supportive measures to maintain blood pressure of greater than or equal to 90mmHg)

- end-organ hypoperfusion (cool extremities or a urine output of <30ml/hour, and a heart rate ≥60 beats/minute)

- a cardiac index of no more than 2.2 l/min per square meter of body-surface area and a pulmonary-capillary wedge pressure of at least 15 mmHg.

CODE 2 Cardiac rupture

Use this code when the person has a rupture of the ventricular myocardium, the ventricular septum, or a frank papillary muscle rupture. This includes if the person experienced the rupture before presentation to the hospital.

CODE 3 Cardiac arrest

Use this code when the person has experienced cardiac arrest (i.e. the lack of effective cardiac output), including if the person was under arrest at the time of presentation to the hospital.

CODE 4 New or recurrent myocardial infarction

Use this code when the person experiences a myocardial infarction during hospitalisation distinct from the index event at the time of presentation.

Recurrent myocardial infarction is defined by clinical events and cardiac marker elevations after the first 24 hours following presentation to the hospital.

For people presenting without initial evidence of myonecrosis, recurrent MI is defined by:

- A rise in troponin T or I to greater than the diagnostic threshold level (with precision of 10% coefficient of variation) as defined by the local laboratory; OR

- A CK-MB elevation of greater than twice the upper limit of normal for the laboratory (if CK-MB is not available, CK may be used).

For people presenting with evidence of myonecrosis:

- A further rise in troponin of greater than 25% or a re-elevation in CK-MB of greater than 50% (if no CK-MB is drawn, CK may be used) will define recurrent MI

- If the event occurs within 24 hours of PCI, then a level of greater than 3 times the upper limit of normal for CK-MB will be used. If the event occurs within 24 hours of CABG, then a level of greater than 5 times the upper limit of normal for CK-MB will be used.

CODE 5 Stroke

Use this code if the person experiences a loss of neurological function with residual symptoms remaining for at least 24 hours after onset and which occurred before presentation to the hospital. The occurrence of stroke should be evidenced by a record of cerebral imaging (CT or MRI).

CODE 6 Acute pulmonary oedema/congestive heart failure

Use this code when the person has experienced acute pulmonary oedema or congestive heart failure with evidence of supportive clinical signs of ventricular dysfunction. These include:

- Third heart sound (S3)

- Cardiomegaly

- Elevated jugular venous pressure (JVP)

- Chest X-ray evidence of pulmonary congestion

- Requirement for ventilatory assistance (CPAP or intubation).

This includes if acute pulmonary oedema or congestive heart failure was present at the time of presentation to the hospital.

CODE 7 Recurrent rest angina with electrocardiogram (ECG) changes

Use this code when the person has experienced recurrent ischaemic pain occurring at rest believed to be cardiac in origin with associated ECG changes.

CODE 8 Recurrent rest angina without electrocardiogram (ECG) changes

Use this code when the person has experienced recurrent ischaemic pain occurring at rest believed to be cardiac in origin without associated ECG changes.

CODE 9 New onset arrhythmia: atrial

Use this code when the person has experienced an atrial arrhythmia, that was not present before this acute coronary syndrome event, documented by one of the following:

- Atrial fibrillation/flutter

- Supraventricular tachycardia requiring treatment (i.e. requiring cardioversion, drug therapy, or is sustained for greater than one minute).

CODE 10 New onset arrhythmia: ventricular

Use this code when the person has experienced ventricular tachycardia or ventricular fibrillation requiring cardioversion and/or intravenous antiarrhythmics, that was not present before this acute coronary syndrome event.

CODE 11 New onset arrhythmia: heart block (1,2,3)

Use this code when the person has experienced first, second or third degree atrioventricular block with bradycardia with or without the requirement for pacing.

CODE 12 Unplanned revascularisation

Use this code when the person has undergone revascularisation precipitated by 20 minutes or more of recurrent chest pain with/or without objective evidence of ischaemia on the ECG.

Code 13 Acute renal failure

Use this code when the person has acute renal failure as determined by a rise in serum creatinine of x 1.5 or a decrease in GFR by 25% or urine output <0.5mL/kg/h for 6 hours.

Code 14 Thrombocytopenia

Use this code when the person has thrombocytopenia as determined by the platelet count: platelet count dropped to less than 100 x 10^9/L.

Data element attributes

Collection and usage attributes

Guide for use:

Record all clinical events that the person experiences from the time of presentation to hospital until discharge from hospital.

More than one event may be recorded.

The time and date must be recorded for each clinical event that occurs.

Comments:

An acute coronary syndrome (ACS) related clinical event is a clinical event which can affect the health outcomes of a person with ACS.

Information on the occurrence of these clinical events in people with ACS is required due to an emerging appreciation of their relationship with late mortality.

Source and reference attributes

Reference documents:

Chew DPB et al. National data elements for the clinical management of acute coronary syndromes. Medical Journal of Australia. Volume 182 Number 9. 2 May 2005.

Relational attributes

Implementation in Data Set Specifications:

Acute coronary syndrome clinical event cluster Health, Standard 01/10/2008

Conditional obligation:
If a clinical event has occurred, record the clinical event type.

Acute coronary syndrome related medical history

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—acute coronary syndrome related medical history, code NN
METeOR identifier:	356598
Registration status:	Health, Standard 01/10/2008
Definition:	A person's history of acute coronary syndrome related medical conditions as represented by a code.
Data Element Concept:	Person—acute coronary syndrome related medical history

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
11	Angina (excluding unstable angina): prior existing
12	Angina (excluding unstable angina): new onset
13	Unstable angina
21	Chronic lung disease
31	Heart failure
41	Hypertension
51	Ischaemic: non-haemorrhagic cerebral infarction
52	Haemorrhagic: intracerebral haemorrhage
61	Peripheral artery disease
62	Aortic aneurysm
63	Renal artery stenosis
71	Sleep apnoea
81	Previous myocardial infarction
91	Atrial fibrillation
92	Other dysrhythmia or conductive disorder
93	Left ventricular hypertrophy

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Angina:

CODE 11 Angina (excluding unstable angina): prior existing

This code is used where there are symptoms, which can be described as chest pain or pain in either or both shoulders, the back, neck or jaw, or other equivalent discomfort (such as tightness, gripping or squeezing) suggestive of cardiac ischaemia, the onset of which occured more than two weeks ago.

CODE 12 Angina (excluding unstable angina): new onset

This code is used where there are symptoms which can be described as chest pain or pain in either or both shoulders, the back, neck or jaw, or other equivalent discomfort (such as tightness, gripping or squeezing) suggestive of cardiac ischaemia; the onset of which occured two or less weeks ago.

CODE 13 Unstable angina

This code is used where a person has experienced new onset or prior existing angina (described as chest pain or pain in either or both shoulders, the back, neck or jaw, or other equivalent discomfort (such as tightness, gripping or squeezing)), which is increasing in severity, duration or frequency.

Chronic lung disease:

CODE 21 Chronic lung disease

This code is used where there is a history or symptoms suggestive of chronic lung disease.

Heart failure:

CODE 31 Heart failure

This code is used where a person has past or current symptoms of heart failure (typically breathlessness or fatigue), either at rest or during physical activity and/or signs of pulmonary or peripheral congestion suggestive of cardiac dysfunction.

Hypertension:

CODE 41 Hypertension

This code is used where there is current use of pharmacotherapy for hypertension and/or clinical evidence of high blood pressure.

CODE 51 Ischaemic: non-haemorrhagic cerebral infarction

This code is used if there is history of stroke or cerebrovascular accident (CVA) resulting from an ischaemic event where the patient suffered a loss of neurological function with residual symptoms remaining for at least 24 hours.

CODE 52 Haemorrhagic: intracerebral haemorrhage

This code is used if there is history of stroke or cerebrovascular accident (CVA) resulting from a haemorrhagic event where the patient suffered a loss of neurological function with residual symptoms remaining for at least 24 hours.

Peripheral arterial disease:

CODE 61 Peripheral artery disease

This code is used where there is history of either chronic or acute occlusion or narrowing of the arterial lumen in the aorta or extremities.

CODE 62 Aortic aneurysm

This code is used where there is a history of aneurysmal dilatation of the aorta (thoracic and or abdominal).

CODE 63 Renal artery stenosis

This code is used where there is a history of functional stenosis of one or both renal arteries.

Sleep apnoea syndrome:

CODE 71 Sleep apnoea

This code is used where there is evidence of sleep apnoea syndrome (SAS) on history.

Myocardial infarction:

CODE 81 Previous myocardial infarction

This code is used where a person has previously experienced a myocardial infarction, excluding the current event that prompted this presentation to hospital. This may be supported by clinical documentation and evidenced by ECG changes or serum cardiac biomarker changes.

Other vascular conditions:

CODE 91 Atrial fibrillation

This code is used where there is a history or symptoms suggestive of atrial fibrillation.

CODE 92 Other cardiac arrhythmias or conductive disorders

This code is used where there is a history of other cardiac arrhythmias or conductive disorders.

CODE 93 Left ventricular hypertrophy

This code is used where there is a history or symptoms suggestive of left ventricular hypertrophy.

Data element attributes

Collection and usage attributes

Guide for use:	More than one medical condition may be recorded. Record only those codes that apply. Record all codes that apply.
Collection methods:	Where codes 21, 31, 51, 52, 61, 62, 63, 71, 91, 92 and 93 are recorded Person - clinical evidence status (acute coronary syndrome related medical conditions), yes/no code N must also be recorded.
Comments:	A history of the listed medical conditions is pertinent to the risk stratification and treatment of acute coronary syndrome.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Reference documents:	National Heart Foundation of Australia & Cardiac Society of Australia and New Zealand. Guidelines for the management of acute coronary syndromes 2006. Med J Aust 2006; 184; S1-S32. © MJA 2006

Relational attributes

Related metadata references:	Supersedes Person—acute coronary syndrome concurrent clinical condition, code NN Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Acute coronary syndrome stratum

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—acute coronary syndrome risk stratum, code N
METeOR identifier:	356665
Registration status:	Health, Standard 01/10/2008
Definition:	Risk stratum of a person presenting with clinical features consistent with an acute coronary syndrome defined by accompanying clinical, electrocardiogram (ECG) and biochemical features, as represented by a code.
Data Element Concept:	Person—acute coronary syndrome risk stratum

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	ST-segment-elevation (myocardial infarction)
2	Non-ST-segment-elevation ACS with high-risk features
3	Non-ST-segment-elevation ACS with intermediate-risk features
4	Non-ST-segment-elevation ACS with low-risk features

Supplementary values:

Value	Meaning
9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 ST-segment-elevation (myocardial infarction)

This code is used where persistent ST elevation of >=1mm in two contiguous limb leads, or ST elevation of >=2mm in two contiguous chest leads, or with new left bundle -branch block (BBB) pattern on the ECG.

This classification is intended for identification of patients potentially eligible for reperfusion therapy, either pharmacologic or intervention-based. Other considerations such as the time to presentation and the clinical appropriateness of instituting reperfusion are not reflected in this metadata item.

CODE 2 Non-ST-segment-elevation ACS with high-risk features

This code is used when presentation with clinical features consistent with an acute coronary syndrome with high-risk features which include any of the following:

- repetitive or prolonged (> 10 minutes) ongoing chest pain or discomfort;
- elevated level of at least one cardiac biomarker (troponin or creatine kinase-MB isoenzyme);
- persistent or dynamic ECG changes of ST segment depression >= 0.5mm or new T wave >= 2mm;
- transient ST-segment elevation (>= 0.5 mm) in more than 2 contiguous leads;
- haemodynamic compromise: Blood pressure < 90 mmHg systolic, cool peripheries, diaphoresis, Killip Class > 1, and/or new onset mitral regurgitation;
- sustained ventricular tachycardia;
- syncope;
- left ventricular systolic dysfunction (left ventricular ejection fraction < 0.40);
- prior percutaneous coronary intervention within 6 months or prior coronary artery bypass surgery;
- presence of known diabetes (with typical symptoms of ACS);or
- chronic kidney disease (estimated glomerular filtration rate < 60mL/minute) (with typical symptoms of ACS).

This classification is intended for identification of patients potentially eligible for aggressive medical management and coronary angiography and revascularisation.

CODE 3 Non-ST-segment-elevation ACS with intermediate-risk features

This code is used when presentation with clinical features consistent with an acute coronary syndrome and any of the following intermediate-risk features AND NOT meeting the criteria for high-risk ACS:

- chest pain or discomfort within the past 48 hours that occurred at rest, or was repetitive or prolonged (but currently resolved);
- age greater than 65yrs;
- known coronary heart disease: prior myocardial infarction with left ventricular ejection fraction >= 0.40 known coronary lesion more than 50% stenosed;
- no high-risk changes on electrocardiography (see high-risk features);
- two or more of the following risk factors: known hypertension, family history, active smoking or hyperlipidaemia;
- presence of known diabetes (with atypical symptoms of ACS);
- chronic kidney disease (estimated glomerular filtration rate < 60mL/minute) (with atypical symptoms of ACS); or
- prior aspirin use.

This classification is intended for identification of patients potentially eligible for accelerated diagnostic evaluation and further risk stratification.

CODE 4 Non-ST-segment-elevation ACS with low-risk features

This code is used when presentation with clinical features consistent with an acute coronary syndrome without intermediate or high-risk features of non-ST-segment-elevation ACS. This includes onset of anginal symptoms within the last month, or worsening in severity or frequency of angina, or lowering of anginal threshold.

This classification is intended for identification of patients potentially eligible for outpatient investigation discharge on upgraded medical therapy and outpatient investigation.

Data element attributes

Collection and usage attributes

Guide for use:

Other clinical considerations influencing the decision to admit and investigate are not reflected in this metadata item. This metadata item is intended to simply provide a diagnostic classification at the time of, or within hours of clinical presentation.

Acute coronary syndrome symptoms may include:

- tightness, pressure, heaviness, fullness or squeezing in the chest which may spread to the neck and throat, jaw, shoulders, the back, upper abdomen, either or both arms and even into the wrists and hands
- dyspnoea, nausea/vomiting, cold sweat or syncope.

Collection methods:

Recorded at time of presentation.

Only one code should be recorded.

Must be recorded in conjunction with Person—acute coronary syndrome procedure type, code NN and Person—clinical procedure timing, code N.

Comments:

The clinical, electrocardiogram and biochemical characteristics are important to enable early risk stratification.

Source and reference attributes

Submitting organisation:

Acute coronary syndrome data working group

Origin:

National Heart Foundation of Australia & Cardiac Society of Australia and New Zealand. Guidelines for the management of acute coronary syndromes 2006. Med J Aust 2006; 184; S1-S32. © MJA 2006

The TIMI Risk Score for Unstable Angina/Non-ST Elevation MI JAMA. 2000; 284:835-842.

Relational attributes

Related metadata references:

Supersedes Person—acute coronary syndrome risk stratum, code N Health, Superseded 01/10/2008

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Additional diagnosis

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—additional diagnosis, code (ICD-10-AM 7th edn) ANN{.N[N]}
METeOR identifier:	391322
Registration status:	Health, Standard 22/12/2009
Definition:	A condition or complaint either coexisting with the principal diagnosis or arising during the episode of admitted patient care, episode of residential care or attendance at a health care establishment, as represented by a code.
Data Element Concept:	Episode of care—additional diagnosis

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:	Record each additional diagnosis relevant to the episode of care in accordance with the ICD-10-AM Australian Coding Standards. 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. Additional diagnoses give information on the conditions that are significant in terms of treatment required, investigations needed and resources used during the episode of care. They are used for casemix analyses relating to severity of illness and for correct classification of patients into Australian Refined Diagnosis Related Groups (AR-DRGs).
Collection methods:	An additional diagnosis should be recorded and coded where appropriate upon separation of an episode of admitted patient care or the end of an episode of residential care or attendance at a health care establishment. The additional diagnosis is derived from and must be substantiated by clinical documentation.

Comments:

Additional diagnoses should be interpreted as conditions that affect patient management in terms of requiring any of the following:

- Commencement, alteration or adjustment of therapeutic treatment
- Diagnostic procedures
- Increased clinical care and/or monitoring

In accordance with the Australian Coding Standards, certain conditions that do not meet the above criteria may also be recorded as additional diagnoses.

Additional diagnoses are significant for the allocation of Australian Refined Diagnosis Related Groups. The allocation of patient 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 of condition codes, should be sequenced together with the additional diagnosis codes so that meaning is given to the data for use in injury surveillance and other monitoring activities.

Source and reference attributes

Origin: National Centre for Classification in Health

Relational attributes

Related metadata references:

Supersedes Episode of care—additional diagnosis, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v 6) NN Health, Standard 22/12/2009

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v 6) ANNA Health, Standard 22/12/2009

Implementation in Data Set Specifications:

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Admitted patient mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Admitted patient palliative care NMDS 2010-11 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Residential mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Address line (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—address line, text [X(180)]
Synonymous names:	Australian address line
METeOR identifier:	286620
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	A composite of one or more standard **address** components that describes a low level of geographical/physical description of a location, as represented by text. Used in conjunction with the other high-level address components i.e. Suburb/town/locality, Postcode—Australian, Australian state/territory, and Country, forms a complete geographical/physical address of a person.
Data Element Concept:	Person (address)—address line

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(180)]
Maximum character length:	180

Data element attributes

Collection and usage attributes

Guide for use:

A high-level address component is defined as a broad geographical area that is capable of containing more than one specific physical location. Some examples of a broad geographical area are:

- Suburb, town or locality

- Postcode—Australian or international

- State, Territory, local government area, electorate, statistical local area

- Postal delivery point identifier

- Countries, provinces, etc other than in Australia

These components of a complete address do not form part of the Address line.

When addressing an Australian location, following are the standard address data elements that may be concatenated in the Address line:

- Building/complex sub-unit type

- Building/complex sub-unit number

- Building/property name

- Floor/level number

- Floor/level type

- House/property number

- Lot/section number

- Street name

- Street type code

- Street suffix code

One complete identification/description of a location/site of an address can comprise one or more than one instance of address line.

Instances of address lines are commonly identified in electronic information systems as Address-line 1, Address-line 2, etc.

The format of data collection is less important than consistent use of conventions in the recording of address data. Hence, address may be collected in an unstructured manner but should ideally be stored in a structured format.

Where Address line is collected as a stand-alone item, software may be used to parse the Address line details to separate the sub-components.

Multiple Address lines may be recorded as required.

Collection methods:

The following concatenation rules should be observed when collecting address lines addressing an Australian location.

- Building/complex sub-unit type is to be collected in conjunction with Building/complex sub-unit number and vice versa.

- Floor/level type is to be collected in conjunction with Floor/level number and vice versa.

- Street name is to be used in conjunction with Street type code and Street suffix code.

- Street type code is to be used in conjunction with Street name and Street suffix code.

- Street suffix code is to be used in conjunction with Street name and Street type code.

- House/property number is to be used in conjunction with Street name.

Source and reference attributes

Submitting organisation: Standards Australia

Origin: Health Data Standards Committee

AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia.

Reference documents: AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

Related metadata references:

Is formed using Person (address)—street suffix, code A[A] Health, Standard 01/03/2005, Community services, Standard 30/09/2005

Is formed using Person (address)—street type, code A[AAA] Health, Standard 01/03/2005, Community services, Standard 30/09/2005

Is formed using Person (address)—street name, text [A(30)] Health, Standard 01/03/2005, Community services, Standard 30/09/2005

Is formed using Person (address)—lot/section identifier, N[X(14)] Health, Standard 01/03/2005, Community services, Standard 30/09/2005

Is formed using Person (address)—house/property identifier, text [X(12)] Health, Standard 01/03/2005, Community services, Standard 30/09/2005

Is formed using Person (address)—floor/level type, code A[A] Health, Standard 01/03/2005, Community services, Standard 30/09/2005

Is formed using Person (address)—floor/level identifier, [NNNA] Health, Standard 01/03/2005, Community services, Standard 30/09/2005

Is formed using Person (address)—building/complex sub-unit type, code A[AAA] Health, Standard 01/03/2005, Community services, Standard 30/09/2005

Is formed using Person (address)—building/complex sub-unit identifier, [X(7)] Health, Standard 01/03/2005, Community services, Standard 30/09/2005

Is formed using Person (address)—building/property name, text [X(30)] Health, Standard 01/03/2005, Community services, Standard 30/09/2005

Supersedes Person (address)—health address line, text [X(180)] Health, Superseded 04/05/2005

Implementation in Data Set Specifications:

Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Superseded 06/03/2009

Cancer (clinical) DSS Health, Superseded 22/12/2009

Cancer (clinical) DSS Health, Standard 22/12/2009

Health care client identification DSS Health, Superseded 03/12/2008

Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Superseded 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Address line (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—address line, text [X(180)]
METeOR identifier:	290315
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	A composite of one or more standard **address** components, as represented by text.
Data Element Concept:	Service provider organisation (address)—address line

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(180)]
Maximum character length:	180

Data element attributes

Collection and usage attributes

Guide for use:

A high-level address component is defined as a broad geographical area that is capable of containing more than one specific physical location. Some examples of a broad geographical area are:

- Suburb, town or locality
- Postcode
- Australian or international
- State, Territory, local government area, electorate, statistical local area
- Postal delivery point identifier
- Countries, provinces, etc. other than in Australia

These components of a complete address do not form part of the Address line.

When addressing an Australian location, following are the standard address data elements that may be concatenated in the Address line:

- Building/complex sub-unit type
- Building/complex sub-unit number
- Building/property name
- Floor/level number

- Floor/level type
- House/property number
- Lot/section number
- Street name
- Street type code
- Street suffix code

One complete identification/description of a location/site of an address can comprise one or more than one instance of address line. Instances of address lines are commonly identified in electronic information systems as Address-line 1, Address-line 2, etc. The format of data collection is less important than consistent use of conventions in the recording of address data. Hence, address may be collected in an unstructured manner but should ideally be stored in a structured format. Where Address line is collected as a stand-alone item, software may be used to parse the Address line details to separate the sub-components. Multiple Address lines may be recorded as required.

Collection methods:

The following concatenation rules should be observed when collecting address lines addressing an Australian location.

- Building/complex sub-unit type is to be collected in conjunction with Building/complex sub-unit number and vice versa.
- Floor/level type is to be collected in conjunction with Floor/level number and vice versa.
- Street name is to be used in conjunction with Street type code and Street suffix code.
- Street type code is to be used in conjunction with Street name and Street suffix code.
- Street suffix code is to be used in conjunction with Street name and Street type code.
- House/property number is to be used in conjunction with Street name.

Source and reference attributes

Submitting organisation: Standards Australia

Origin: Health Data Standards Committee

AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia.

Reference documents: AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references:

Is formed using Service provider organisation (address)—street suffix, code A[A] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is formed using Service provider organisation (address)—street type, code A[AAA] Health, Standard 04/05/2005, Community

services, Standard 30/09/2005

Is formed using Service provider organisation (address)—street name, text [A(30)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is formed using Service provider organisation (address)—lot/section identifier, N[X(14)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is formed using Service provider organisation (address)—house/property identifier, text [X(12)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is formed using Service provider organisation (address)—floor/level type, code A[A] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is formed using Service provider organisation (address)—floor/level identifier, [NNNA] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is formed using Service provider organisation (address)—building/complex sub-unit type, code A[AAA] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is formed using Service provider organisation (address)—building/complex sub-unit identifier, [X(7)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is formed using Service provider organisation (address)—building/property name, text [X(30)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Implementation in Data Set Specifications:

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Superseded 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Address type (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—address type, code N
METeOR identifier:	286728
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	A code set representing a type of address, as represented by a code.
Data Element Concept:	Person (address)—address type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Business
2	Mailing or postal
3	Residential
4	Temporary residential

Supplementary values:

9	Unknown/Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Business

This code is used to indicate an address that is the physical location of a business, an office or from where a service is delivered.

CODE 2 Mailing or postal

This code is used to indicate an address that is only for correspondence purposes.

CODE 3 Residential

This code is used to indicate where a person is living. Note that this code is not valid for organisations.

CODE 4 Temporary residential

Temporary accommodation address (such as for a person from rural Australia who is visiting an oncology centre for a course of treatment, or a person who usually resides overseas). Note that this is not valid for organisations.

CODE 9 Unknown/Not stated/inadequately described

This code may also be used where the person has no fixed address or does not wish to have their residential or a correspondence address recorded.

Data element attributes

Collection and usage attributes

Guide for use:

A single address may have multiple address types associated with it. Record as many as required.

Collection methods:

At least one address must be recorded (this may be an unknown Address type).

Health care establishments should always attempt to collect the residential address of a person who is a health care client when a service is provided. When recording the address for a health care provider or organisation, the business address should always be collected. In addition, other addresses may also need to be recorded for individuals and organisations.

Overseas address:

For individuals record the overseas address as the residential address and record a temporary accommodation address as their contact address in Australia.

Comments:

'No fixed address' is coded as unknown because it (the concept) is not a type of address for a person but is an attribute of the person only i.e. it is not a location for which an address may be derived. It is not recommended that an implementation collects this attribute as an address type. A person not having a fixed address constrains the number of address types that can be collected i.e. temporary accommodation and residential address types cannot be collected. However, if it is imperative that this occurs, it is suggested that code 9 be used.

Source and reference attributes

Submitting organisation:

Standards Australia

Australian Institute of Health and Welfare

Origin:

AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia

Reference documents:

AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia
In AS4846 and AS5017 alternative alphabetic codes are presented. Refer to the current standard for more details.

Relational attributes

Related metadata references:

Supersedes Person (address)—address type, code A Health, Superseded 04/05/2005

Implementation in Data Set Specifications:

Health care client identification DSS Health, Superseded 03/12/2008

Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Superseded 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Address type (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—address type, code N
METeOR identifier:	286792
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The type of geographical/physical location where an organisation can be located, as represented by a code.
Data Element Concept:	Service provider organisation (address)—address type

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Business
	2	Mailing or postal
Supplementary values:	9	Unknown/Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Business

This code is used to indicate an address that is the physical location of a business, an office or from where a service is delivered.

CODE 2 Mailing or postal

This code is used to indicate an address that is only for correspondence purposes.

CODE 9 Unknown/Not stated/inadequately described

This code may also be used where the person has no fixed address or does not wish to have their residential or a correspondence address recorded

Data element attributes

Collection and usage attributes

Guide for use: A single address may have multiple address types associated with it. Record as many as required.

Collection methods:

At least one address must be recorded (this may be an unknown Address type). When recording the address for a health care provider or organisation, the business address should always be collected. In addition, other addresses may also need to be recorded for individuals and organisations.

Source and reference attributes

Origin:

AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia

Reference documents:

AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

In AS4846 and AS5017 alternative alphabetic codes are presented. Refer to the current standard for more details.

Relational attributes

Implementation in Data Set Specifications:

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Superseded 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Address—country identifier (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—country identifier, code (SACC 2008) NNNN
METeOR identifier:	370937
Registration status:	Health, Standard 01/10/2008 Community services, Standard 02/06/2008
Definition:	The country component of the address of a person, as represented by a code.
Data Element Concept:	Person (address)—country identifier

Value domain attributes

Representational attributes

Classification scheme:	Standard Australian Classification of Countries 2008
Representation class:	Code
Data type:	Number
Format:	NNNN
Maximum character length:	4

Collection and usage attributes

Guide for use:	The Standard Australian Classification of Countries 2008 (SACC) is a four-digit, three-level hierarchical structure specifying major group, minor group and country. 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.

Data element attributes

Collection and usage attributes

Collection methods:	Collect the data at the 4-digit level.
Comments:	Note that the Standard Australian Classification of Countries (SACC) is mappable to but not identical to Australian Standard Classification of Countries for Social Statistics (ASCCSS).

Source and reference attributes

Reference documents:	Standard Australian Classification of Countries Edition 2, Catalogue number 1269.0, 2008, Canberra: Australian Bureau of Statistics

Relational attributes

Related metadata references:	Supersedes Person (address)—country identifier, code (SACC 1998) NNNN Health, Superseded 01/10/2008, Community services, Superseded 02/06/2008
Implementation in Data Set Specifications:	Health care client identification DSS Health, Standard 03/12/2008
	Health care provider identification DSS Health, Standard 03/12/2008

Administrative health region name

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Administrative health region—region name, text [A(80)]
METeOR identifier:	297639
Registration status:	Health, Standard 05/12/2007
Definition:	Textual description of the full name of an administrative health region.
Data Element Concept:	Administrative health region—region name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[A(80)]
Maximum character length:	80

Data element attributes

Collection and usage attributes

Guide for use:	Administrative health regions are determined by the relevant state or territory.

Source and reference attributes

Submitting organisation:	Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications:	Palliative care performance indicators DSS Health, Standard 05/12/2007

Administrative health region palliative care strategic plan indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Administrative health region—palliative care strategic plan indicator, yes/no code N
METeOR identifier:	288331
Registration status:	Health, Standard 05/12/2007
Definition:	Whether an administrative health region has a written strategic plan which incorporates palliative care elements, as represented by a code.
Data Element Concept:	Administrative health region—palliative care strategic plan indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

A palliative care strategic plan may be an entire health region's plan, or an aggregation of the region's sub-units' plans. The plan may be specifically for palliative care or a general health service plan that includes palliative care elements.

The palliative care elements in the plan must include all of the following aspects:

- timeframe (the beginning and end-date in years), with a minimum time period of two years to demonstrate a strategic focus
- measurable objectives relating to: service access, quality, utilisation, responsiveness and evaluation
- demonstrated stakeholder involvement in plan development, such as the inclusion of a description of the consultation process in the strategic plan document
- demonstrated links with the National Palliative Care Strategy

- implementation strategies (can include resources identified for service delivery)
- evidence of ongoing development in subsequent plans.

A strategic plan typically has a mission statement, outlines a vision, values and strategies, and includes goals and objectives. A strategic plan may: serve as a framework for decisions; provide a basis for more detailed planning; explain the business to others in order to inform, motivate and involve; assist benchmarking and performance monitoring; stimulate change and become a building block for next plan.

The plan will ideally address both palliative care at the specialist level and palliative care at the primary care (i.e. non-specialist) level.

CODE 1 Yes
The administrative health region has a written strategic plan which incorporates palliative care elements, and which includes all specified strategic plan aspects.

CODE 2 No
The administrative health region does not have a written strategic plan which incorporates palliative care elements, or has a plan with only partial coverage of the specified strategic plan aspects.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications: Palliative care performance indicators DSS Health, Standard 05/12/2007

Admission date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—admission date, DDMMYYYY
METeOR identifier:	269967
Registration status:	Health, Standard 01/03/2005
Definition:	Date on which an admitted patient commences an episode of care.
Data Element Concept:	Episode of admitted patient care—admission date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Admission date, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB)

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v 6) NN Health, Standard 22/12/2009

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v 6) ANNA Health, Standard 22/12/2009

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA Health, Superseded 22/12/2009

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN Health, Superseded 22/12/2009

Is used in the formation of Episode of admitted patient care—length of stay (including leave days), total N[NN] Health, Standard 04/07/2007

Is used in the formation of Episode of admitted patient care—length of stay (including leave days) (antenatal), total N[NN] Health, Standard 04/07/2007

Is used in the formation of Episode of admitted patient care—length of stay (excluding leave days), total N[NN] Health, Standard 01/03/2005

Is used in the formation of Episode of care—number of psychiatric care days, total N[NNNN] Health, Standard 01/03/2005

Is used in the formation of Episode of admitted patient care—length of stay (including leave days), total N[NN] Health, Superseded 04/07/2007

Is used in the formation of Episode of admitted patient care (antenatal)—length of stay (including leave days), total N[NN] Health, Superseded 04/07/2007

Is used in the formation of Non-admitted patient emergency department service episode—waiting time (to hospital admission), total hours and minutes NNNN Health, Standard 01/03/2005

Is used in the formation of Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Admitted patient palliative care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient palliative care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient palliative care NMDS 2007-08 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient palliative care NMDS 2008-09 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient palliative care NMDS 2009-10 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient palliative care NMDS 2010-11 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Admission time

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—admission time, hhmm
METeOR identifier:	269972
Registration status:	Health, Standard 01/03/2005
Definition:	Time at which an admitted patient commences an episode of care.
Data Element Concept:	Episode of admitted patient care—admission time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Comments:	Required to identify the time of commencement of the episode or hospital stay, for calculation of waiting times and length of stay.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Admission time, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.5 KB) Is used in the formation of Non-admitted patient emergency department service episode—waiting time (to hospital admission), total hours and minutes NNNN Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Admitted patient election status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—patient election status, code N
METeOR identifier:	326619
Registration status:	Health, Standard 23/10/2006
Definition:	Accommodation chargeable status elected by a patient on **admission**, as represented by a code.
Data Element Concept:	Episode of admitted patient care—patient election status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Public
2	Private

Collection and usage attributes

Guide for use:

Public patient:

A person, eligible for Medicare, who receives or elects to receive a public hospital service free of charge.

Includes: patients in public psychiatric hospitals who do not have the choice to be treated as a private patient. Also includes overseas visitors who are covered by a reciprocal health care agreement, and who elect to be treated as public patients.

Private patient:

A person who elects to be treated as a private patient and elects to be responsible for paying fees for the type referred to in clause 49 of the Australian Health Care Agreements (2003–2008).

Clause 49 states that:

Private patients, compensable patients and ineligible persons may be charged an amount for public hospital services as determined by (the state or territory).

All patients in private hospitals (other than those receiving public hospital services and electing to be treated as a public patient) are private patients.

Includes: all patients who are charged (regardless of the level of the charge) or for whom a charge is raised for a third party payer (for example, Department of Veterans' Affairs and Compensable patients). Also includes patients who are Medicare ineligible and

receive public hospital services free of charge at the discretion of the hospital, and prisoners, who are Medicare ineligible while incarcerated.

Data element attributes

Collection and usage attributes

Guide for use:

Australian Health Care Agreements 2003–08 state that eligible persons are to be given the choice to receive, free of charge as public patients, health and emergency services.

At the time of, or as soon as practicable after, admission for a public hospital service, the patient must elect in writing to be treated as either

- a public patient or
- a private patient

This item is independent of the patient's hospital insurance status and room type.

Notes:
Inability to sign: In cases where the patient is unable to complete the patient election form, the patient should be assumed to be a public patient.

Compensation funding decisions: A patient may be recorded as a public patient as an interim patient election status while the patient's compensable status is being decided.

Inter-hospital contracted care: If the patient receives inter-hospital contracted care the following guidelines can be used if no further information is available:

- If the patient received contracted care that was purchased by a public hospital then it will be assumed that they elected to be treated as a public patient.
- If the patient received contracted care that was purchased by a private hospital then it will be assumed that they elected to be treated as a private patient.

Source and reference attributes

Submitting organisation: Admitted patient care NMDS Technical Reference Group

Relational attributes

Related metadata references: Supersedes Episode of admitted patient care—elected accommodation status, code N Health, Superseded 23/10/2006

Implementation in Data Set Specifications: Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Age

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—age, total years N[NN]
METeOR identifier:	303794
Registration status:	Health, Standard 08/02/2006 Community services, Standard 29/04/2006 Housing assistance, Standard 10/02/2006
Definition:	The age of the person in (completed) years at a specific point in time.
Context:	Age is a core data element in a wide range of social, labour and demographic statistics. It is used in the analyses of service utilisation by age group and can be used as an assistance eligibility criterion.
Data Element Concept:	Person—age

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	N[NN]	
Maximum character length:	3	
Supplementary values:	Value	Meaning
	999	Unknown/not stated
Unit of measure:	Year	

Data element attributes

Collection and usage attributes

Guide for use:	Age in single years (if aged under one year, record as zero). If age (or date of birth) is unknown or not stated, and cannot be estimated, use Code 999. National community services and housing assistance data dictionary specific: If year of birth is known (but date of birth is not) use the date, 0101YYYY of the birth year to estimate age (where YYYY is the year of birth). National housing assistance data dictionary specific: In the housing assistance data collections age is calculated at 30 June for the corresponding year.
Collection methods:	Although collection of date of birth allows more precise calculation of age, this may not be feasible in some data collections, and alternative questions are: Age last birthday? What was ..... age last birthday?

	What is ..... age in complete years?
Comments:	National community services data dictionary specific: Different rules for reporting data may apply when estimating the Date of birth of children aged under 2 years since the rapid growth and development of children within this age group means that a child's development can vary considerably over the course of a year. Thus, more specific reporting of estimated age is recommended. Those who need to conduct data collections for children where age is collected in months, weeks, or days should do so in a manner that allows for aggregation of those results to this standard.

Source and reference attributes

Submitting organisation:	National Public Health Information Working Group
Origin:	Australian Bureau of Statistics, *Standards for Social, Labour and Demographic Variables*. Reference through: http://www.abs.gov.au/AUSSTATS/abs@.nsf/DirClassManualsbyCatalogue/76CD93AA32E74B29CA25713E0005A2EA?OpenDocument

Relational attributes

Related metadata references:	See also Person—date of birth, MMYYYY Health, Standard 10/12/2009 Supersedes Person—age, total years N[NN] Health, Superseded 08/02/2006
Implementation in Data Set Specifications:	Computer Assisted Telephone Interview demographic module DSS Health, Superseded 03/12/2008 Computer Assisted Telephone Interview demographic module DSS Health, Standard 03/12/2008

Age range

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—age range, code NN
METeOR identifier:	290540
Registration status:	Health, Standard 04/05/2005
Definition:	The age range that best accommodates a person's completed age in years, at the time of data collection, as represented by a code.
Data Element Concept:	Person—age range

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	0-4
02	5-14
03	15-24
04	25-34
05	35-44
06	45-54
07	55-64
08	65-74
09	75 years or older

Supplementary values:

Value	Meaning
99	Not stated

Data element attributes

Collection and usage attributes

Guide for use:	Used in computer assisted telephone interview (CATI) surveys in cases where the specific age is not available. Depending on the collection a different starting age may be used, but should map back to the standard output. Information at a finer level can be collected as long as it maps back to the proposed data domain, e.g. 75+ age group can be split into 75-84 and 85 years or older.
Collection methods:	Although collection of date of birth allows more precise calculation of age, as does the collection of a single age, this may not always be feasible. Age range should be derived from a

question on date of birth or age at last birthday.

Comments: In cases where an exact age is not known or not stated, age may be reported as an age range. The age ranges are consistent with the standard 10 year ranges recommended by the ABS.

Source and reference attributes

Submitting organisation: National Public Health Information Working Group

Origin: ABS, Statistical Concepts Library, Standards for Social, Labour and Demographic Variables. Age.

Reference documents: Reference through: http://www.abs.gov.au/Ausstats/abs@.nsf/StatsLibrary and choose, Other ABS Statistical Standards, Standards for Social, Labour and Demographic Variables, Demographic Variables, Age.

Relational attributes

Implementation in Data Set Specifications: Computer Assisted Telephone Interview demographic module DSS Health, Superseded 03/12/2008

Computer Assisted Telephone Interview demographic module DSS Health, Standard 03/12/2008

Alcohol consumption frequency (self reported)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—alcohol consumption frequency (self-reported), code NN
METeOR identifier:	270247
Registration status:	Health, Standard 01/03/2005
Definition:	A person's self-reported frequency of alcohol consumption, as represented by a code.
Data Element Concept:	Person—alcohol consumption frequency

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Every day/7 days per week
02	5 to 6 days per week
03	3 to 4 days per week
04	1 to 2 days per week
05	2 to 3 days per month
06	Once per month
07	7 to 11 days in the past year
08	4 to 6 days in the past year
09	2 to 3 days in the past year
10	Once in the past year
11	Never drank any alcoholic beverage in the past year
12	Never in my life

Supplementary values:

Value	Meaning
99	Not reported

Data element attributes

Collection and usage attributes

Collection methods: The World Health Organisation, in its 2000 International Guide for Monitoring Alcohol Consumption and Related Harm document, suggests that in assessing alcohol consumption patterns a 'Graduated Quantity Frequency' method is preferred. This method requires that questions about the quantity and frequency of alcohol consumption should be asked to help determine short-term and long-term health consequences. This

information can be collected (but not confined to) the following ways:

- in a clinical setting with questions asked by a primary healthcare professional
- as a self-completed questionnaire in a clinical setting
- as part of a health survey
- as part of a computer aided telephone interview.

It should be noted that, particularly in telephone interviews, the question(s) asked may not be a direct repetition of the Value domain; yet they may still yield a response that could be coded to the full Value domain or a collapsed version of the Value domain.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Origin: Australian Alcohol Guidelines: Health Risks and Benefits, National Health & Medical Research Council, October 2001

Relational attributes

Related metadata references: Supersedes Alcohol consumption frequency- self report, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (24.3 KB)

Implementation in Data Set Specifications: Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Alcohol consumption in standard drinks per day (self reported)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—alcohol consumption amount (self-reported), total standard drinks NN
METeOR identifier:	270249
Registration status:	Health, Standard 01/03/2005
Definition:	A person's self-reported usual number of alcohol-containing standard drinks on a day when they consume alcohol.
Data Element Concept:	Person—alcohol consumption amount

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NN
Maximum character length:	2

Supplementary values:

Value	Meaning
99	Consumption not reported

Unit of measure: Standard drink

Collection and usage attributes

Guide for use: Alcohol consumption is usually measured in standard drinks.

An Australian standard drink contains 10 grams of alcohol, which is equivalent to 12.5 millilitres of alcohol.

Data element attributes

Collection and usage attributes

Guide for use: This estimation is based on the person's description of the type (spirits, beer, wine, other) and number of standard drinks, as defined by the National Health and Medical Research Council (NH&MRC), consumed per day. One standard drink contains 10 grams of alcohol.

The following gives the NH&MRC examples of a standard drink:

- Light beer (2.7%):
  - 1 can or stubbie = 0.8 a standard drink
- Medium light beer (3.5%):
  - 1 can or stubbie = 1 standard drink
- Regular Beer - (4.9% alcohol):

- 1 can = 1.5 standard drinks
- 1 jug = 4 standard drinks
- 1 slab (cans or stubbies) = about 36 standard drinks

- Wine (9.5% - 13% alcohol):
  - 750-ml bottle = about 7 to 8 standard drinks
  - 4-litre cask = about 30 to 40 standard drinks
- Spirits:
  - 1 nip = 1 standard drink
  - Pre-mixed spirits (around 5% alcohol) = 1.5 standard drinks

When calculating consumption in standard drinks per day, the total should be reported with part drinks recorded to the next whole standard drink (e.g. 2.4 = 3).

Collection methods:

The *World Health Organisation's 2000 International Guide for Monitoring Alcohol Consumption and Related Harm document* suggests that in assessing alcohol consumption patterns a 'Graduated Quantity Frequency' method is preferred. This method requires that questions about the quantity and frequency of alcohol consumption should be asked to help determine short-term and long-term health consequences.

Source and reference attributes

Submitting organisation:

Cardiovascular Data Working Group

Origin:

The World Health Organisation's 2000 International Guide for Monitoring Alcohol Consumption and Related Harm document - National Health and Medical Research Council's Australian Alcohol Guidelines, October 2001.

Relational attributes

Related metadata references:

Supersedes Alcohol consumption in standard drinks per day - self report, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.6 KB)

Implementation in Data Set Specifications:

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Anaesthesia administered for operative delivery of the baby

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—anaesthesia administered, code N
METeOR identifier:	292044
Registration status:	Health, Standard 07/12/2005
Definition:	Anaesthesia administered to the woman for the operative delivery of the baby, as represented by a code.
Data Element Concept:	Birth event—anaesthesia administered

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	None
2	Local anaesthetic to perineum
3	Pudendal
4	Epidural or caudal
5	Spinal
6	General anaesthetic
7	Combined spinal-epidural
8	Other

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	Operative delivery includes caesarean section, forceps and vacuum extraction. Code 7: this code is used when this technique has been selected for the administration of anaesthesia for the operative delivery of the baby.
Collection methods:	More than one agent or technique can be recorded, except where 1=none applies. This item should only be recorded for the operative delivery of the baby and not third stage labour e.g. removal of placenta.

Comments: 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.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Birth event—anaesthesia administered, code N Health, Superseded 07/12/2005

Analgesia administered for labour

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—analgesia administered, code N
METeOR identifier:	292546
Registration status:	Health, Standard 07/12/2005
Definition:	Analgesia administered to the woman to relieve pain for labour, as represented by a code.
Data Element Concept:	Birth event—analgesia administered

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	None
2	Nitrous oxide
4	Epidural or caudal
5	Spinal
6	Systemic opioids
7	Combined spinal-epidural
8	Other
Supplementary values: 9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	
Comments:	Note: Code 3, which had a meaning in previous versions of the data standard is no longer used. As is good practice, the code will not be reused.

Data element attributes

Collection and usage attributes

Guide for use:	Systemic opioids include both intra-muscular and intravenous opioids. Code 7: this code is used when this technique has been selected for the administration of analgesia for labour.
Collection methods:	More than one agent or technique can be recorded, except where 1=none applies.

	This item is to be recorded for first and second stage labour, but not third stage labour e.g. removal of placenta.
Comments:	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.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Birth event—analgesia administered, code N Health, Superseded 07/12/2005

Angina status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—angina status, Canadian Cardiovascular Society code N
METeOR identifier:	338335
Registration status:	Health, Standard 01/10/2008
Definition:	The limitation of physical activity experienced by a person with the onset of angina, as represented by the Canadian Cardiovascular Society code.
Data Element Concept:	Person—angina status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	No angina with ordinary physical activity
2	Slight limitation of ordinary physical activity
3	Marked limitation of ordinary physical activity
4	Inability for any physical activity without anginal symptoms

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Code 1 No angina with ordinary physical activity

Use this code for patients who have no angina on ordinary physical activity such as walking or stair climbing. Angina occurs with strenuous, rapid or prolonged exertion at work or recreation.

Code 2 Slight limitation of ordinary physical activity

Use this code for patients for whom angina occurs on walking or climbing stairs rapidly, walking uphill, walking or climbing stairs after a meal, or under emotional stress, or in the cold, or only during the first few hours after waking.

Code 3 Marked limitation or ordinary physical activity

Use this code for patients where angina occurs walking one or two blocks on the level and climbing one or more flights of stairs in normal conditions and at a normal pace.

	Code 4 Inability for any physical activity without anginal symptoms Use this code for patients who are unable to carry on any physical activity without discomfort - anginal symptoms may be present at rest.
Collection methods:	Angina status is self-reported by the person but is interpreted, coded and recorded by the health professional.

Data element attributes

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Angiotensin converting enzyme (ACE) inhibitors therapy status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—angiotensin converting enzyme inhibitors therapy status, code NN
METeOR identifier:	284751
Registration status:	Health, Standard 04/06/2004
Definition:	The person's ACE inhibitor therapy status, as represented by a code.
Data Element Concept:	Person—angiotensin converting enzyme inhibitors therapy status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
10	Given
21	Not given - patient refusal
22	Not given - allergy or intolerance (e.g. cough) to ACE inhibitors
23	Not given - moderate to severe aortic stenosis
24	Not given - bilateral renal artery stenosis
25	Not given - history of angio-oedema, hives, or rash in response to ACE inhibitors
26	Not given - hyperkalaemia
27	Not given - symptomatic hypotension
28	Not given - severe renal dysfunction
29	Not given - other

Supplementary values:

90	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODES 21 - 29 Not given

If recording 'Not given', record the principal reason if more than one code applies.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Angiotensin converting enzyme (ACE) inhibitors therapy status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008
	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Anticipated patient election status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—anticipated accommodation status, code N
METeOR identifier:	270074
Registration status:	Health, Standard 01/03/2005
Definition:	Accommodation chargeable status nominated by the patient when placed on an elective surgery waiting list, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode—anticipated accommodation status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Public
2	Private

Collection and usage attributes

Guide for use:

CODE 1 Public patient:

An eligible person who receives or elects to receive a public hospital service free of charge.

CODE 2 Private patient:

An eligible person who elects to be treated as a private patient; 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'.

Data element attributes

Collection and usage attributes

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

Patients whose charges are to be met by the Department of Veterans' Affairs are regarded as private patients.

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 Australian Health Care 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.

Relational attributes

Related metadata references:

Supersedes Anticipated patient election status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (15.2 KB)

Apgar score at 1 minute

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth—Apgar score (at 1 minute), code NN
METeOR identifier:	289345
Registration status:	Health, Standard 07/12/2005
Definition:	Numerical score used to indicate the baby's condition at 1 minute after birth.
Data Element Concept:	Birth—Apgar score

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	String	
Format:	NN	
Maximum character length:	2	
Permissible values:	Value	Meaning
	00-10	Apgar score
Supplementary values:	99	Not stated/inadequately described

Collection and usage attributes

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.

Data element attributes

Collection and usage attributes

Comments:	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.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Birth—Apgar score (at 1 minute), code NN Health, Superseded 07/12/2005

Apgar score at 5 minutes

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth—Apgar score (at 5 minutes), code NN
METeOR identifier:	289360
Registration status:	Health, Standard 07/12/2005
Definition:	Numerical score used to indicate the baby's condition at 5 minutes after birth.
Data Element Concept:	Birth—Apgar score

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	String	
Format:	NN	
Maximum character length:	2	
Permissible values:	Value	Meaning
	00-10	Apgar score
Supplementary values:	99	Not stated/inadequately described

Collection and usage attributes

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.

Data element attributes

Collection and usage attributes

Comments:	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.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Birth—Apgar score (at 5 minutes), code NN Health, Superseded 07/12/2005
Implementation in Data Set Specifications:	Perinatal NMDS Health, Superseded 06/09/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007

Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Perinatal NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Area of practice—dental

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—principal area of practice, dental code NN
METeOR identifier:	377981
Registration status:	Health, Standard 10/12/2009
Definition:	The area of dental practice in which a dentist spent the most hours in their main job in the week prior to registration, as represented by a code.
Data Element Concept:	Registered health professional—principal area of practice

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	General dental practice
02	Dento-maxillofacial radiology
03	Endodontics
04	Oral and maxillofacial surgery
05	Oral surgery
06	Oral medicine
07	Oral pathology
08	Orthodontics
09	Paedodontics
10	Periodontics
11	Prosthodontics
12	Public health dentistry
13	Special needs dentistry

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 01 GENERAL DENTAL PRACTICE

That part of dental practice that deals with a range of general dental care.

CODE 02 DENTO-MAXILLOFACIAL RADIOLOGY

That part of dental practice that deals with diagnostic imaging procedures applicable to the hard and soft tissues of the oral and

maxillofacial region and to other structures which are relevant for the proper assessment of oral conditions.

CODE 03 ENDODONTICS

That part of dental practice that deals with the morphology, physiology, and pathology of the human tooth and, in particular, the dental pulp, root and peri-radicular tissues. It includes the biology of the normal pulp, crown, root and peri-radicular tissues and the aetiology, prevention, diagnosis and treatment of diseases and injuries that affect these tissues.

CODE 04 ORAL AND MAXILLOFACIAL SURGERY

That part of dental practice that deals with the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects of the human jaws and associated structures.

CODE 05 ORAL SURGERY

That part of dental practice that deals with the diagnosis, surgical and adjunctive treatment of diseases and injuries limited to the dento-alveolar complex.

CODE 06 ORAL MEDICINE

That part of dental practice that deals with the clinical diagnosis, assessment and principally non-surgical, pharmacological management of anatomical variants, pathological conditions, diseases and pain of the dental, oral and adjacent anatomical structures and the dental/oral manifestations and complications of systemic diseases, pathology and conditions and their treatment.

CODE 07 ORAL PATHOLOGY

That part of dental practice that deals with diseases of the teeth, jaws, oral soft tissues and associated structures, studies their causes, pathogenesis and effects, and by use of clinical, radiographic, microscopic and other laboratory procedures establishes differential diagnoses and provides forensic evaluations.

CODE 08 ORTHODONTICS

That part of dental practice that deals with the study and supervision of the growth and development of the dentition and its related anatomical structures, including preventive and corrective procedures of dentofacial irregularities requiring the re-positioning of teeth, jaws, and/or soft tissues by functional or mechanical means.

CODE 09 PAEDIATRIC DENTISTRY (PAEDODONTICS)

That part of dental practice that deals with the prevention and the treatment of dental diseases and abnormalities in children and their associated developmental and behavioural problems.

CODE 10 PERIODONTICS

That part of dental practice that deals with the prevention, recognition, diagnosis and treatment of the diseases and disorders of the investing and supporting tissues of natural teeth or their substitutes.

CODE 11 PROSTHODONTICS

That part of dental practice that deals with the restoration and maintenance of oral health, function and appearance by coronal alteration or reconstruction of natural teeth, or the replacement of missing teeth and contiguous oral and maxillofacial tissues with substitutes.

CODE 12 PUBLIC HEALTH DENTISTRY

That part of dental practice that deals with the community as the patient rather than the individual, being concerned with oral health education of the public, applied dental research and administration of dental care programmes including prevention and control of oral diseases on a community basis.

CODE 13 SPECIAL NEEDS DENTISTRY

That part of dental practice that deals with patients where intellectual disability, medical, physical or psychiatric conditions require special methods or techniques to prevent or treat oral health problems, or where such conditions necessitate special dental treatment plans.

Registered health professionals on leave at the time of registration are asked to report their usual principle area of practice worked.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Australian Dental Association
Reference documents:	Australian Dental Association Policy Statement 2.4, November 2008 *Specialisation in Dentistry*

Data element attributes

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Health professional—area of clinical practice (principal), code ANN Health, Superseded 10/12/2009
Implementation in Data Set Specifications:	Main job of registered dental and allied dental health professional cluster Health, Standard 10/12/2009
	Second job of registered dental and allied dental health professional cluster Health, Standard 10/12/2009

Area of practice—midwifery

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—principal area of practice, midwifery code NN
METeOR identifier:	382168
Registration status:	Health, Standard 10/12/2009
Definition:	The area of midwifery practice in which a midwife spent the most hours in their main job in the week prior to registration, as represented by a code.
Data Element Concept:	Registered health professional—principal area of practice

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Antenatal care
02	Care during labour and birth
03	Continuum of midwifery care
04	Maternal and child health
05	Midwifery education
06	Midwifery management
07	Midwifery research
08	Neonatal care
09	Postnatal care
10	Other

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Collection and usage attributes

Guide for use: The midwifery care during the woman's pregnancy, labour and birth and the postnatal period as well as the care of the well, normal baby is undertaken in partnership with the woman, consulting and referring to other health professionals as required. This care also includes preventative measures, the promotion of normal birth, the detection of complication in mother and child, accessing medical care or other appropriate assistance and the carrying out of emergency measures.

CODE 01 ANTENATAL CARE

Care, including counselling and education of the woman, and care of her unborn baby from the time the woman's pregnancy is diagnosed until the onset of labour.

CODE 02 CARE DURING LABOUR AND BIRTH

Care, including advocacy and support of the woman and her baby during all stages of labour and during the baby's birth.

CODE 03 CONTINUUM OF MIDWIFERY CARE

Care across the continuum of the woman's pregnancy, labour, the baby's birth and the post natal period.

CODE 04 MATERNAL AND CHILD HEALTH

Care of the mother and child following the postnatal period of 6 weeks focussing on parenting and the child's growth and development, up until at least the age of 5 years and in some cases beyond that age.

CODE 05 MIDWIFERY EDUCATION

The design, planning, implementation, delivery and evaluation of midwifery education and/or staff development programs and management of educational resources.

CODE 06 MIDWIFERY MANAGEMENT

The management of a health unit or sub-unit of a service, hospital or community health care facility providing midwifery services and care, supervising midwives and the financial resources to enable the provision safe, cost effective midwifery care within the service and monitors quality, clinical standards and the professional development of midwives.

CODE 07 MIDWIFERY RESEARCH

The design, planning, implementation and evaluation of midwifery research programs and projects and management of research resources.

CODE 08 NEONATAL CARE

Care and close observation of the normal well newborn baby ensuring the baby's continued well being, growth and development in the first 6 weeks of life.

CODE 09 POSTNATAL CARE

Care, including counselling and education of the woman and care of her baby from the baby's birth until the baby is 6 weeks old.

CODE 10 OTHER

All other areas of midwifery not covered above.

Registered health professionals on leave at the time of registration are asked to report their usual principle area of practice worked.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Health professional—area of clinical practice (principal), code ANN Health, Superseded 10/12/2009

Implementation in Data Set Specifications: Main job of registered midwife cluster Health, Standard 10/12/2009

Second job of registered midwife cluster Health, Standard 10/12/2009

Area of practice—nursing

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—principal area of practice, nursing code NN
METeOR identifier:	377983
Registration status:	Health, Standard 10/12/2009
Definition:	The area of nursing practice in which a nurse spent the most hours in their main job in the week prior to registration, as represented by a code.
Data Element Concept:	Registered health professional—principal area of practice

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Aged care
02	Child and family health
03	Community health
04	Critical care and emergency
05	Education
06	Management
07	Medical
08	General practice/Medical practice
09	Mental health
10	Midwifery
11	Paediatrics
12	Peri-operative
13	Rehabilitation and disability
14	Research
15	Surgical
16	Other

Supplementary values:

99	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 01 AGED CARE

Nursing care to the elderly in community settings, residential aged care facilities, retirement villages and health care facilities.

CODE 02 CHILD AND FAMILY HEALTH

Nursing care to children from birth to school age and their families with an emphasis on the prevention, early detection of, and early intervention in, physical, emotional and social problems affecting children and their families such as assistance with parentcraft, immunisation and developmental milestones.

CODE 03 COMMUNITY HEALTH

Nursing care, health counselling, screening and education to individuals, families and groups in the wider community with a focus on patient independence and health promotion.

CODE 04 CRITICAL CARE AND EMERGENCY

Provides nursing care to critically ill patients and patients with unstable health following injury, surgery or during the acute phase of diseases, integrating new technological equipment into care in settings such as high dependency units, intensive care units, emergency departments or retrieval services.

CODE 05 EDUCATION

Design, planning, implementation, evaluation and delivery of nursing education and staff development programs, and management of educational resources.

CODE 06 MANAGEMENT

Management of a health service unit or sub-unit of a hospital, aged care or community health care facility, supervision of nursing staff and financial resources to enable the provision of safe, cost effective nursing care within a specified field or for a particular unit, and monitoring of quality, clinical standards and professional development of nurses.

CODE 07 MEDICAL

Nursing care to patients with conditions, such as infections, metabolic disorders and degenerative conditions, which require medical intervention in a range of health, aged care and community settings.

CODE 08 GENERAL PRACTICE/MEDICAL PRACTICE

Clinical care to patients, clinical organisation and practice administration, and the facilitation of communication within a general practice environment and between the practice and outside organisations and individuals.

CODE 09 MENTAL HEALTH

Nursing care to patients with mental health illness, disorder and dysfunction, and those experiencing emotional difficulties, distress and crisis in health, welfare and aged care facilities, correctional services and the community.

CODE 10 MIDWIFERY

Nursing care and advice to women during pregnancy, labour and childbirth, and postnatal care for women and babies in a range of settings such as the home, community, hospitals, clinics and health units.

CODE 11 PAEDIATRICS

Providing nursing care and advice regarding internal diseases and disorders in children from birth up to, and including, adolescence.

CODE 12 PERI-OPERATIVE

Nursing care to patients before, during and immediately after surgery, assessment of patients' condition, planning of nursing care for surgical intervention, maintenance of a safe and comfortable environment, assistance to Surgeons and Anaesthetists during surgery, and monitoring of patients' recovery from anaesthetic, prior to return to, or discharge from, ward.

CODE 13 REHABILITATION AND DISABILITY

Nursing care to patients recovering from injury and illness, and assistance and facilitation for patients with disabilities to live more independently.

CODE 14 RESEARCH

The design, conduct and evaluation of nursing and interdisciplinary research projects, and promotion of the implementation of research findings into clinical nursing practice.

CODE 15 SURGICAL

Nursing care to patients with injuries and illness that require surgical intervention.

CODE 16 OTHER

All other areas of nursing practice not covered above.

Registered health professionals on leave at the time of registration are asked to report their usual principle area of practice worked.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: These definitions are based on occupational definitions as described in the Australian and New Zealand Standard Classification of Occupations, First Edition (ABS cat. no. 1220.0)

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Health professional—area of clinical practice (principal), code ANN Health, Superseded 10/12/2009

Implementation in Data Set Specifications: Main job of registered nursing professional cluster Health, Standard 10/12/2009

Second job of registered nursing professional cluster Health, Standard 10/12/2009

Area of practice—psychology

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—principal area of practice, psychology code NN
METeOR identifier:	377985
Registration status:	Health, Standard 10/12/2009
Definition:	The area of psychology practice in which a psychologist spent the most hours in their main job in the week prior to registration, as represented by a code.
Data Element Concept:	Registered health professional—principal area of practice

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Assessment
02	Psychological intervention
03	Community psychology
04	Management/Administration
05	Organisational psychology
06	Research
07	Teaching/supervision

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 01 ASSESSMENT

Includes behavioural, neuropsychological, cognitive, medico-legal, and educational.

CODE 02 PSYCHOLOGICAL INTERVENTION

Includes counselling, mental health intervention, personal development/coaching, physical health and lifestyle intervention, intervention for drug and/or alcohol misuse and/or other addiction.

CODE 03 COMMUNITY PSYCHOLOGY

Includes mental health promotion, community engagement/education, health promotion.

CODE 04 MANAGEMENT/ADMINISTRATION

Includes planning and coordination of psychology programs and services, maintaining standards of care, provision of leadership to ensure an appropriately skilled workforce, and contribution to health service planning.

CODE 05 ORGANISATIONAL PSYCHOLOGY

Includes organisational practices, consulting/advising for work purposes, recruitment and vocational assessment.

CODE 06 RESEARCH

Includes research design and implementation, statistical analysis, project/program development and evaluation.

CODE 07 TEACHING/SUPERVISION

Includes teaching, supervision and assessment of the psychological work of a student, provisional/probationary psychologist or a colleague.

CODE 08 OTHER

Includes all other areas of psychology practice not defined above.

Registered health professionals on leave at the time of registration are asked to report their usual principle area of practice worked.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Categories and definitions are based on advice from the Australian Psychological Society Ltd - www.psychology.org.au

Reference documents:

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Health professional—area of clinical practice (principal), code ANN Health, Superseded 10/12/2009

Implementation in Data Set Specifications: Main job of registered psychologist cluster Health, Standard 10/12/2009

Second job of registered psychologist cluster Health, Standard 10/12/2009

Area of usual residence

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—area of usual residence, geographical location code (ASGC 2009) NNNNN
METeOR identifier:	386783
Registration status:	Health, Standard 02/10/2009
Definition:	Geographical location of usual residence of the person, as represented by a code.
Data Element Concept:	Person—area of usual residence

Value domain attributes

Representational attributes

Classification scheme:	Australian Standard Geographical Classification 2009
Representation class:	Code
Data type:	Number
Format:	NNNNN
Maximum character length:	5

Data element attributes

Collection and usage attributes

Guide for use:

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 (ASGC).

The ASGC is updated on an annual basis with a date of effect of 1 July each year. The codes for SLA 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 SLA.

The Australian Bureau of Statistics' (ABS) National Localities Index (NLI) (ABS Catalogue number 1252.0) can be used to assign each locality or address in Australia to a SLA. The NLI is a comprehensive list of localities in Australia with their full code (including State or Territory and 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 a 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 person's residence is used with the Streets Sub-index of the NLI to assign the SLA.

If the information available on the person's address indicates that it is in a split locality but is insufficient to assign an SLA, the code for the SLA which includes most of the split locality should be reported. This is in accordance with the NLI assignment of SLA when a split locality is identified and further detail about the address is not available.

The NLI does not assign a SLA 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 SLA within Australia (State or Territory unstated), undefined SLA 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.

Collection methods:

When collecting the geographical location of a person's usual place of residence, the Australian Bureau of Statistics (ABS) recommends that 'usual' be defined as: 'the place where the person has or intends to live for 6 months or more, or the place that the person regards as their main residence, or where the person has no other residence, the place they currently reside.' Apart from collecting a person's usual place of residence there is also a need in some collections to collect area of residence immediately prior to or after assistance is provided, or at some other point in time.

Comments:

Geographical location is reported using Statistical Local Area (SLA) to enable accurate aggregation of information to larger areas within the Australian Standard Geographical Classification (ASGC) (such as Statistical Subdivisions and Statistical Divisions) as well as detailed analysis at the SLA level. The use of SLA also allows analysis relating the data to information complied by the Australian Bureau of Statistics on the demographic and other characteristics of the population of each SLA. Analyses facilitates by the inclusion of SLA 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 attributes

Related metadata references:

Supersedes Person—area of usual residence, geographical location code (ASGC 2008) NNNNN Health, Superseded 02/10/2009

Implementation in Data Set Specifications:

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Admitted patient mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Admitted patient palliative care NMDS 2010-11 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Community mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Non-admitted patient emergency department care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Perinatal NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Residential mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Aspirin therapy status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—aspirin therapy status, code NN
METeOR identifier:	284785
Registration status:	Health, Standard 04/06/2004
Definition:	The person's aspirin therapy status, as represented by a code.
Data Element Concept:	Person—aspirin therapy status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
10	Given
21	Not given - patient refusal
22	Not given - true allergy to aspirin
23	Not given - active bleeding
24	Not given - bleeding risk
29	Not given - other

Supplementary values:

90	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODES 21 - 29 Not given

If recording 'Not given', record the principal reason if more than one code applies.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references: Supersedes Aspirin therapy status, version 1, DE, NHDD,

	NHIMG, Superseded 01/03/2005.pdf (14.2 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008
	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Assistance with activities

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—need for assistance with activities in a life area, code N
METeOR identifier:	320213
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The level of help and/or supervision a person requires (or would require if the person currently helping/supervising was not available) to perform tasks and actions in a specified life area, as represented by a code.
Context:	Human functioning and disability
Data Element Concept:	Person—need for assistance with activities in a life area

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Functioning, Disability and Health 2001
Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
0	Does not need help/supervision
1	Sometimes needs help/supervision
2	Always needs help/supervision
3	Unable to do this task or action, even with assistance

Supplementary values:

Value	Meaning
8	Not specified
9	Not applicable

Collection and usage attributes

Guide for use:

This metadata item contributes to the definition of the concept **'Disability'** and gives an indication of the experience of disability for a person.

In the context of health, an activity is the execution of a task or action by an individual. Activity limitations are difficulties an individual may have in executing an activity.

Activity limitation varies with the environment and is assessed in relation to a particular environment; the absence or presence of assistance, including aids and equipment, is an aspect of the environment.

This value domain records the level of a person's need for help or supervision, in a specified domain, in their overall life. This means that the need for assistance may not be directly relevant to the health or community care service being provided.

Where a life area includes a range of examples, (e.g. domestic life includes cooking, cleaning and shopping), if a person requires assistance in any of the areas then the highest level of assistance should be recorded.

Where need for assistance varies markedly over time (e.g. episodic psychiatric conditions) please record the average level of assistance needed.

The presence of an activity limitation with a given domain is indicated by a non-zero response in this value domain. Activity is limited when an individual, in the context of a health condition, either has need for assistance in performing an activity in an expected manner, or cannot perform the activity at all.

CODE 0 is used when the person has no need for supervision or help and can undertake the activity independently.

CODE 1 is used when the person sometimes needs assistance to perform an activity.

CODE 2 is used when the person always needs assistance to undertake the activity and cannot do the activity without assistance.

CODE 3 is used when the person cannot do the activity even with assistance

CODE 8 is used when a person's need for assistance to undertake the activity is unknown or there is insufficient information to use codes 0-3.

CODE 9 is used where the need for help or supervision is due to the person's age. For example, Education for persons less than 5 years and work for persons less than 15 years.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin: WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents: Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website http://www.who.int/classifications/icf/en/
- Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.html

Data element attributes

Collection and usage attributes

Guide for use: This data element, in conjunction with Person—activities and participation life area, code (ICF 2001) AN[NNN], indicates a person's need for assistance in a given domain of activity.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references: See also Person—activity and participation life area, code (ICF 2001) AN[NNN] Health, Standard 29/11/2006, Community services, Standard 16/10/2006

Implementation in Data Set Specifications: Activities and Participation cluster Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Australian State/Territory identifier (establishment)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—Australian state/territory identifier, code N
METeOR identifier:	269941
Registration status:	Health, Standard 01/03/2005
Definition:	An identifier of the Australian state or territory in which an establishment is located, as represented by a code.
Data Element Concept:	Establishment—Australian state/territory identifier

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
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)

Collection and usage attributes

Guide for use: The order presented here is the standard for the Australian Bureau of Statistics (ABS). Other organisations (including the Australian Institute of Health and Welfare) publish data in state order based on population (that is, Western Australia before South Australia and Australian Capital Territory before Northern Territory).

Source and reference attributes

Reference documents: Australian Bureau of Statistics. Australian Standard Geographical Classification (ASGC). Cat No. 1216.0. Canberra: ABS.

Data element attributes

Collection and usage attributes

Guide for use: This metadata item applies to the location of the establishment and not to the patient's area of usual residence.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: National Health Data Committee

National Community Services Data Committee

Relational attributes

Related metadata references:

Supersedes Australian State/Territory identifier, version 4, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005.pdf (18.8 KB)

Is used in the formation of Service delivery outlet—geographic location, code (ASGC 2009) NNNNN Health, Standard 02/10/2009

Is used in the formation of Establishment—geographical location, code (ASGC 2009) NNNNN Health, Standard 02/10/2009

Is used in the formation of Service delivery outlet—geographic location, code (ASGC 2008) NNNNN Health, Superseded 02/10/2009

Is used in the formation of Establishment—geographical location, code (ASGC 2008) NNNNN Health, Superseded 02/10/2009

Is used in the formation of Establishment—geographical location, code (ASGC 2007) NNNNN Health, Superseded 04/02/2009

Is used in the formation of Service delivery outlet—geographic location, code (ASGC 2007) NNNNN Health, Superseded 04/02/2009

Is used in the formation of Service delivery outlet—geographic location, code (ASGC 2006) NNNNN Health, Superseded 05/02/2008

Is used in the formation of Establishment—geographical location, code (ASGC 2006) NNNNN Health, Superseded 05/02/2008

Is used in the formation of Establishment—geographical location, code (ASGC 2005) NNNNN Health, Superseded 14/09/2006

Is used in the formation of Service delivery outlet—geographic location, code (ASGC 2005) NNNNN Health, Superseded 14/09/2006

Is used in the formation of Establishment—organisation identifier (Australian), NNX[X]NNNNN Health, Standard 01/03/2005

Is used in the formation of Service delivery outlet—geographic location, code (ASGC 2004) NNNNN Health, Superseded 21/03/2006

Implementation in Data Set Specifications:

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Community mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Community mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Community mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Community mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Residential mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Residential mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Australian State/Territory identifier (jurisdiction)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Jurisdiction—Australian state/territory identifier, code N
METeOR identifier:	352480
Registration status:	Health, Standard 05/12/2007
Definition:	An identifier of the Australian state or territory of a jurisdiction, as represented by a code.
Data Element Concept:	Jurisdiction—Australian state/territory identifier

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
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)

Collection and usage attributes

Guide for use: The order presented here is the standard for the Australian Bureau of Statistics (ABS). Other organisations (including the Australian Institute of Health and Welfare) publish data in state order based on population (that is, Western Australia before South Australia and Australian Capital Territory before Northern Territory).

Source and reference attributes

Reference documents: Australian Bureau of Statistics. Australian Standard Geographical Classification (ASGC). Cat No. 1216.0. Canberra: ABS.

Data element attributes

Source and reference attributes

Submitting organisation: Health expenditure advisory committee

Relational attributes

Implementation in Data Set Specifications:

Government health expenditure NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Government health expenditure NMDS 2009-2010 Health, Standard 01/04/2009

Implementation start date: 01/07/2009

Australian state of birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—Australian state/territory of birth, code N
METeOR identifier:	375455
Registration status:	Health, Standard 10/12/2009
Definition:	The Australian state/territory in which a person was born, as represented by a code.
Data Element Concept:	Person—state/territory of birth

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
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)

Collection and usage attributes

Guide for use: The order presented here is the standard for the Australian Bureau of Statistics (ABS). Other organisations (including the Australian Institute of Health and Welfare) publish data in state order based on population (that is, Western Australia before South Australia and Australian Capital Territory before Northern Territory).

Source and reference attributes

Reference documents: Australian Bureau of Statistics. Australian Standard Geographical Classification (ASGC). Cat No. 1216.0. Canberra: ABS.

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

Registered chiropractic labour force DSS Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons born in Australia

Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons born in Australia

Registered medical professional labour force DSS Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons born in Australia

Registered midwifery labour force DSS Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons born in Australia

Registered nursing professional labour force DSS Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons born in Australia

Registered optometry labour force DSS Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons born in Australia

Registered osteopathy labour force DSS Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons born in Australia

Registered pharmacy labour force DSS Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons born in Australia

Registered physiotherapy labour force DSS Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons born in Australia

Registered podiatry labour force DSS Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons born in Australia

Registered psychology labour force DSS Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons born in Australia

Australian state/territory identifier

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—Australian state/territory identifier, code N
METeOR identifier:	286919
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 10/02/2006
Definition:	The Australian state or territory where a person can be located, as represented by a code.
Data Element Concept:	Person—Australian state/territory identifier

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
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)

Collection and usage attributes

Guide for use: The order presented here is the standard for the Australian Bureau of Statistics (ABS). Other organisations (including the Australian Institute of Health and Welfare) publish data in state order based on population (that is, Western Australia before South Australia and Australian Capital Territory before Northern Territory).

Source and reference attributes

Reference documents: Australian Bureau of Statistics. Australian Standard Geographical Classification (ASGC). Cat No. 1216.0. Canberra: ABS.

Data element attributes

Collection and usage attributes

Collection methods: Irrespective of how the information is coded, conversion of the codes to the ABS standard must be possible.

Source and reference attributes

Origin: Australian Bureau of Statistics 2004. Australian Standard Geographical Classification (ASGC) (Cat No. 1216.0). Viewed 13 October 2005.

Reference documents: AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

AS5017 Health Care Client Identification, 2004, Sydney: Standards Australia

In AS4846 and AS5017 alternative codes are presented. Refer to the current standard for more details.

Relational attributes

Related metadata references: See also Person (address)—Australian postcode, code (Postcode datafile) {NNNN} Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 10/02/2006

Implementation in Data Set Specifications: Health care client identification DSS Health, Superseded 03/12/2008

Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Superseded 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Australian state/territory identifier (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—Australian state/territory identifier, code N
METeOR identifier:	289083
Registration status:	Health, Standard 04/05/2005 Community services, Standard 07/12/2005
Definition:	An identifier of the Australian state or territory where an organisation or agency can be located, as represented by a code.
Data Element Concept:	Service provider organisation—Australian state/territory identifier

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
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)

Collection and usage attributes

Guide for use: The order presented here is the standard for the Australian Bureau of Statistics (ABS). Other organisations (including the Australian Institute of Health and Welfare) publish data in state order based on population (that is, Western Australia before South Australia and Australian Capital Territory before Northern Territory).

Source and reference attributes

Reference documents: Australian Bureau of Statistics. Australian Standard Geographical Classification (ASGC). Cat No. 1216.0. Canberra: ABS.

Data element attributes

Collection and usage attributes

Collection methods: Irrespective of how the information is coded, conversion of the codes to the ABS standard must be possible.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Health Data Standard Committee

National Community Services Data Committee

Reference documents: AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia

In AS4846 and AS5017 alternative codes are presented. Refer to the current standard for more details.

Relational attributes

Implementation in Data Set Specifications: Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Superseded 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Average available beds for hospital-in-the-home patients

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Occupied bed—hospital in the home care, average number of beds N[NNN.N]
METeOR identifier:	373955
Registration status:	Health, Standard 24/03/2009
Definition:	The number of beds used to care for hospital admitted patients in their place of residence as a substitute for hospital accommodation, calculated by dividing the number of days of **hospital-in-the-home care** reported for the period by the number of days in the period. Place of residence may be permanent or temporary.
Data Element Concept:	Occupied bed—hospital in the home care

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN.N]
Maximum character length:	5
Unit of measure:	Bed

Collection and usage attributes

Guide for use:	Average available beds, rounded to the nearest decimal or whole number.

Data element attributes

Collection and usage attributes

Guide for use:	Calculated by dividing the total hospital-in-the-home patient days by the number of days in the period, e.g. in a normal year, a hospital records 4000 hospital-in-the-home patient days – the average hospital-in-the-home beds would be 4000/365 = 11.0.
Collection methods:	Beds exclusively or predominantly for overnight-stay admitted care, beds exclusively or predominantly for same-day admitted care, and non-special-care neonatal cots are collected and reported in separate categories. Hospitals should establish clear recording and reporting practices. Criteria should exist to ensure that each available bed is counted and that no available bed is counted more than once. A bed should first be assessed as available and then categorised according to its predominant use. For large hospitals a reconciliation of the sum of the counts for the four available bed types and an unduplicated establishment bed count is advisable.

Comments: This data element is necessary to provide an indicator of the availability and type of service for an establishment.

Source and reference attributes

Submitting organisation: Victorian Department of Human Services

Average available beds for overnight-stay patients

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Available bed—overnight-stay admitted care, average number of beds N[NNN.N]
METeOR identifier:	374151
Registration status:	Health, Standard 03/12/2008
Definition:	The number of beds available to provide overnight accommodation for patients (other than neonatal cots (non-special-care) and beds occupied by **hospital-in-the-home patients**), **averaged over the counting period**.
Context:	Public hospital establishments
Data Element Concept:	Available bed—overnight-stay admitted care

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN.N]
Maximum character length:	5
Unit of measure:	Bed

Collection and usage attributes

Guide for use:	Average available beds, rounded to the nearest decimal or whole number.

Data element attributes

Collection and usage attributes

Guide for use:	The number of available beds should be collected at least monthly at the same time on the same day. To improve accuracy data could be collected more frequently (e.g. daily). If so it should be collected at the same time on each day. More frequent data collection is preferable if a single monthly count is likely to be significantly different from the monthly average. Inclusions: Both occupied and unoccupied beds are included in the count as they are deemed as available beds. The number of beds available to provide overnight accommodation is recorded, e.g. maternity ward beds are counted but beds in the delivery suite are not. However, if in a delivery suite patients are admitted, deliver and are discharged from the same bed, such beds should be included because these beds are available for use for overnight-stay patients.

Exclusions: surgical tables, recovery trolleys, delivery beds, discharge lounges for patients who have been formally discharged, medi-hotel beds, beds exclusively or predominantly for same-day admitted care, neonatal cots (non-special-care), hospital-in-the home beds, and beds exclusively or predominantly for non-admitted patients (e.g. emergency trolleys) or residential care. No adjustment should be made for contracted services, either provided by, or to this hospital.

Collection methods:

Beds exclusively or predominantly for overnight-stay admitted care, beds exclusively or predominantly for same-day admitted care and, if required, non-special care neonatal cots are to be collected and reported in separate categories. Hospitals should establish clear recording and reporting practices. Criteria should exist to ensure that each available bed is counted once and only once. A bed should first be assessed as available and then categorised to its predominant use. For large hospitals, a reconciliation of the sum of the bed types and an unduplicated establishment bed count is advisable.

The assessment of availability must reflect the ability of the hospital to provide the necessary resources. This can be significantly impacted by seasonal demand or events such as a strike, clinical staff shortage, fire or renovation. This is illustrated by the following examples.

Example 1: A large hospital, which conducts a daily bed count, has a ward containing 20 beds suitably equipped for overnight admitted patient care. The funding for this ward would allow an average of 15 beds to be staffed over the year. Provided demand is constant and there are no circumstances which prevent these beds from being available for patients, such as a strike, clinical staff shortage, fire or renovation, the hospital would report 15 available beds for this ward.

Example 2: A small hospital, which conducts a monthly bed count, is located in a summer holiday area and has 30 beds suitably equipped for overnight admitted patient care. It manages its resources in such a way that 30 beds are fully staffed during the four months from December to March, but only 15 beds are staffed during the remaining eight months from April to November. The annual average number of available beds is the average of the twelve counts – i.e. ((30 beds x 4 months) + (15 beds x 8 months) divided by 12 counting periods) = 20 beds.

Example 3: A hospital conducts a monthly bed count. Ward A containing 20 beds is closed for six months for a planned renovation. During this period a temporary 10 bed ward (B) is established and the necessary resources are provided. The annual average number of available beds for Ward A is the average of the twelve counts i.e. (20 beds x 6 months) + (0 beds x 6 months) divided by 12 counting periods = 10 beds. The annual average number of available beds for Ward B is (0 beds x 6 months) + (10 beds x 6 months) divided by 12 counting periods = 5 beds.

Example 4: A hospital conducts a daily bed count. A 20 bed ward is closed during the first week of June because of a strike, but for the remainder of June it is fully staffed so that all 20 beds are available. So the average number of beds available for this ward in June is ((0 beds x 7 days) + (20 beds x 23 days) = 460/30 = 15.3.

Comments: This data element is necessary to provide an indicator of the availability and type of service for an establishment.

Source and reference attributes

Submitting organisation: Victorian Department of Human Services

Relational attributes

Related metadata references: Supersedes Establishment—number of available beds for admitted patients/residents, average N[NNN] Health, Superseded 03/12/2008

Implementation in Data Set Specifications: Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Average available beds for residential mental health patients

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Available bed—residential mental health care, average number of beds N[NNN.N]
METeOR identifier:	373650
Registration status:	Health, Standard 03/12/2008
Definition:	The number of beds available in the **specialised residential mental health services** for overnight accommodation, **averaged over the counting period.**
Data Element Concept:	Available bed—residential mental health care

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN.N]
Maximum character length:	5
Unit of measure:	Bed

Collection and usage attributes

Guide for use:	Average available beds, rounded to the nearest decimal or whole number.

Data element attributes

Collection and usage attributes

Guide for use:	Residential mental health beds are available only if they are suitably located and equipped to provide residential mental health care and the necessary financial and human resources can be provided. Average available residential mental health beds are the average bed counts conducted during the year as required. Inclusions: Both occupied and unoccupied residential mental health beds are included.
Collection methods:	Specialised residential mental health care services should establish clear recording and reporting practices and criteria that ensure that each available residential mental health bed is counted and that no available residential mental health bed is counted more than once. The assessment of availability must reflect the ability of the specialised residential mental health care service to provide the necessary resources, and this can be significantly impacted by events such as a strike, clinical staff shortage, fire or renovation.

This is illustrated by the following examples.

Example 1: A specialised residential mental health care service containing 20 residential mental health beds (A) is closed for several months, either for a planned renovation or in response to an unplanned event such as a fire. During this period a temporary 10 specialised residential mental health bed facility (B) is established and the necessary resources are provided. The specialised residential mental health care service would not report the residential mental health beds in facility A, but it would report the 10 residential mental health beds in facility B.

Example 2: A 20 bed specialised residential mental health service is closed during the first week of February because of a strike, but for the remaining three weeks of February it is fully staffed so that all 20 residential mental health beds can be occupied during those three weeks. So the average number of residential mental health beds available for this service in February is 15.

Comments:

This data element is necessary to provide an indicator of the capacity of the residential service.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Average available beds for same-day patients

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Available bed—same-day admitted care, average number of beds N[NNN.N]
METeOR identifier:	373966
Registration status:	Health, Standard 03/12/2008
Definition:	The number of beds, chairs or trolleys available to provide accommodation for same-day patients, **averaged over the counting period**.
Data Element Concept:	Available bed—same-day admitted care

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN.N]
Maximum character length:	5
Unit of measure:	Bed

Collection and usage attributes

Guide for use:	Average available beds, rounded to the nearest decimal or whole number.

Data element attributes

Collection and usage attributes

Guide for use:

The number of beds, chairs or trolleys available to provide accommodation for same-day patients is recorded. Same-day patients are accommodated in the following ways:

1. Patients occupy a single bed or chair in a single location throughout their stay, e.g. dialysis or chemotherapy chair. In this situation the bed or chair is counted as a bed available for same-day patients.
2. Patients occupy a trolley which is moved to different locations throughout their stay – e.g. endoscopy suite, where patients move from the same-day ward to a procedure room, onto a recovery room and back to the same-day ward. In this situation the trolley is counted as a bed available for same-day patients.
3. Same-day patients are accommodated in a general ward after being transferred from another area of the hospital (e.g. Emergency, another ward, etc). In this situation the beds may be counted as either overnight-stay or same-day according to their predominant use.

The number of available same day beds should be collected at least monthly at the same time on the same day. To improve accuracy data could be collected more frequently (e.g. daily) at the same time on each day. More frequent data collection is preferable if a single monthly count is likely to be significantly different from the monthly average.

Inclusions: Both occupied and unoccupied beds are included. Beds, chairs or trolleys available, exclusively or predominantly intended to accommodate same-day admitted care or treatment. This includes day surgery beds, dialysis, chemotherapy, electro-convulsive therapy (ECT) and dental chairs for admitted patients.

Exclusions: Exclude beds, chairs or trolleys designated exclusively for same-day non-admitted patient care or predominantly used by non-admitted patients (e.g. emergency trolleys), medical ambulatory care, discharge lounges for patients who have been formally discharged, medi-hotel beds, hospital-in-the-home, neonatal cots (non-special-care), and beds for overnight-stay patients (even where overnight beds are used for unplanned same-day episodes e.g. patients who die or abscond on the day of admission). No adjustment should be made for contracted services, either provided by, or to this hospital.

Collection methods:

Beds exclusively or predominantly for overnight-stay admitted care, beds exclusively or predominantly for same-day admitted care and, if required, non-special-care neonatal cots are to be collected and reported in separate categories. Hospitals should establish clear recording and reporting practices. Criteria should exist to ensure that each available bed is counted once and only once. A bed should first be assessed as available and then categorised to the most appropriate accommodation category. For large hospitals, a reconciliation of the sum of the bed types and an unduplicated establishment bed count is advisable.

The assessment of availability must reflect the ability of the hospital to provide the necessary resources, and this can be significantly impacted by seasonal demand or events such as a strike, clinical staff shortage, fire or renovation. This is illustrated by the following examples:

Example 1: A large hospital, which conducts a daily bed count, has a ward containing 20 beds suitably equipped for same-day admitted patient care. The funding for this ward would allow an average of 15 beds to be staffed over the year. Provided demand is constant and there are no circumstances which prevent these beds from being available for patients, such as a strike, clinical staff shortage, fire or renovation, the hospital would report 15 available beds for this ward.

Example 2: A hospital located in a summer holiday area, which conducts monthly bed counts, has 12 beds suitably equipped for same-day admitted patient care. It manages its resources in such a way that 12 beds are fully staffed during the four months from December to March, but only 9 beds are staffed during the remaining eight months from April to November. The annual average number of available beds is the average of the twelve monthly averages, i.e. ((12 beds x 4 months) + (9 beds x 8 months) divided by 12 counting periods) = 120/12 = 10 beds.

Example 3: A hospital conducts a monthly bed count. Ward A containing 20 beds is closed for six months, for a planned renovation. During this period a temporary 10 bed ward (B) is established and the necessary resources are provided. The annual average number of available beds for Ward A is the average of the twelve counts, i.e. (20 beds X 6 months) + (0 beds X 6 months) divided by 12 counting periods = 120/12 = 10 beds. The annual average number of available beds for Ward B is (0 beds X 6 months) + (10 beds X 6 months) divided by 12 counting periods = 60/12 = 5 beds.

Example 4: A 20 bed ward is closed during the first week of June because of a strike, but for the remainder of June it is fully staffed so that all 20 beds are available. So the average number of beds available for this ward in June is ((0 beds X 7 days) + (20 beds X 23 days) divided by 30 counting periods) = 460/30 = 15.3.

Comments: This data element is necessary to provide an indicator of the availability and type of service for an establishment.

Source and reference attributes

Origin: Victorian Department of Human Services

Relational attributes

Implementation in Data Set Specifications: Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Average available neonatal cots (non-special-care)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Available bed—neonatal admitted care (Non-special-care), average number of beds N[NNN.N]
METeOR identifier:	373640
Registration status:	Health, Standard 03/12/2008
Definition:	The number of cots available to provide neonatal accommodation, other than special care accommodation, **averaged over the counting period**.
Data Element Concept:	Available bed—neonatal admitted care (Non-special-care)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN.N]
Maximum character length:	5
Unit of measure:	Bed

Collection and usage attributes

Guide for use:	Average available beds, rounded to the nearest decimal or whole number.

Data element attributes

Collection and usage attributes

Guide for use:

Average available cots are the average of 12 monthly (or more frequent) counts of these available cots.

The number of available cots should be collected at least monthly at the same time on the same day. To improve accuracy data could be collected more frequently (e.g. daily). If so, it should be collected at the same time on each day. More frequent data collection is preferable if a single monthly count is likely to be significantly different from the monthly average.

Inclusions: neonatal cots which are not in an intensive care facility approved by the Commonwealth Health Minister for the purpose of the provision of special care. They accommodate unqualified newborns and may also accommodate qualified newborns who do not need to be treated in such a facility (e.g. healthy second twin).

Exclusions: cots in intensive care facilities approved by the Commonwealth Health Minister for the purpose of the provision of special care. Also exclude cots intended to accommodate older (not newborn) babies when they are admitted to hospital. (These cots are reported as available overnight beds.)

Collection methods:

Beds exclusively or predominantly for overnight stay admitted care, beds exclusively or predominantly for same-day admitted care and, if required, non-special care neonatal cots are to be collected and reported in separate categories. Hospitals should establish clear recording and reporting practices. Criteria should exist to ensure that each available bed is counted once and only once. A bed should first be assessed as available and then categorised to its predominant use. For large hospitals, a reconciliation of the sum of the bed types and an unduplicated establishment bed count is advisable.

The assessment of availability must reflect the ability of the hospital to provide the necessary resources. This can be significantly impacted by seasonal demand or events such as a strike, clinical staff shortage, fire or renovation. This is illustrated by the following examples.

Example 1: A large maternity hospital, which conducts a daily bed count, has a ward (not an approved intensive care facility) containing 20 cots used to accommodate newborns. The funding for this ward would allow an average of 15 cots to be staffed over the year. Provided demand is constant and there are no circumstances which prevent these cots from being available for patients, such as a strike, clinical staff shortage, fire or renovation, the hospital would report 15 available cots for this ward.

Example 2: A maternity hospital, which conducts a monthly bed count, has a ward (not an approved intensive care facility) containing 30 cots used to accommodate newborns. It manages its resources in such a way that it is staffed for 30 cots for four months of the year and staffed for 24 cots during the remaining eight months. The annual average number of available cots is the average of the twelve counts – i.e. (30 cots x 4 months) + (24 cots x 8 months) divided by 12 counting periods = (120 + 192)/12 = 26 cots.

Example 3: A hospital conducts a monthly bed count. Ward A containing 20 cots is closed for six months, for a planned renovation. During this period a temporary ward (B) containing 10 cots is established and the necessary resources are provided. The annual average number of available cots in Ward A is the average of the twelve counts, i.e. (20 cots X 6 months) + (0 cots X 6 months) divided by 12 counting periods = 10 cots. The annual average number of available cots for Ward B is (0 cots X 6 months) + (10 cots X 6 months) divided by 12 counting periods = 5 cots.

Example 4: A hospital conducts a daily bed count. A ward containing 20 cots is closed during the first week of June because of a strike, but for the remainder of June it is fully staffed so that all 20 cots are available. So the average number of cots available for this ward in June is ((0 cots X 7 days) + (20 cots X 23 days) = 460/30 = 15.3.

Comments:

This data element is necessary to provide an indicator of the availability and type of service for an establishment.

Source and reference attributes

Origin:

Victorian Department of Human Services

Behaviour-related risk factor intervention

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—behaviour-related risk factor intervention, code NN
METeOR identifier:	270165
Registration status:	Health, Standard 01/03/2005
Definition:	The intervention taken to modify or manage the patient's behaviour-related risk factor(s), as represented by a code.
Data Element Concept:	Episode of care—behaviour-related risk factor intervention

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	No intervention
02	Information and education (not including written regimen)
03	Counselling
04	Pharmacotherapy
05	Referral provided to a health professional
06	Referral to a community program, support group or service
07	Written regimen provided
08	Surgery
98	Other

Supplementary values:

99	Not stated/inadequately defined

Collection and usage attributes

Guide for use:

CODE 01 No intervention

Refers to no intervention taken with regard to the behaviour-related risk factor intervention-purpose.

CODE 02 Information and education (not including written regimen)

Refers to where there is no treatment provided to the patient for a behaviour-related risk factor intervention-purpose other than information and education.

CODE 03 Counselling

Refers to any method of individual or group counselling directed towards the behaviour-related risk factor intervention-purpose. This code excludes counselling activities that are part of referral options as defined in code 05 and 06.

CODE 04 Pharmacotherapy

Refers to pharmacotherapies that are prescribed or recommended for the management of the behaviour-related risk factor intervention-purpose.

CODE 05 Referral provided to a health professional

Refers to a referral to a health professional who has the expertise to assist the patient manage the behaviour-related risk factor intervention-purpose.

CODE 06 Referral to a community program, support group or service

Refers to a referral to community program, support group or service that has the expertise and resources to assist the patient manage the behaviour-related risk factor intervention-purpose.

CODE 07 Written regimen provided

Refers to the provision of a written regimen (nutrition plan, exercise prescription, smoking contract) given to the patient to assist them with the management of the behaviour-related risk factor intervention-purpose.

CODE 08 Surgery

Refers to a surgical procedure undertaken to assist the patient with the management of the behaviour-related risk factor intervention-purpose.

Data element attributes

Collection and usage attributes

Guide for use: More than one code can be recorded.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Relational attributes

Related metadata references: Supersedes Behaviour-related risk factor intervention, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.6 KB)

Implementation in Data Set Specifications:

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Behaviour-related risk factor intervention—purpose

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—behaviour-related risk factor intervention purpose, code N
METeOR identifier:	270338
Registration status:	Health, Standard 01/03/2005
Definition:	The behaviour-related risk factor(s) associated with an intervention(s), as represented by a code.
Data Element Concept:	Episode of care—behaviour-related risk factor intervention purpose

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Smoking
2	Nutrition
3	Alcohol misuse
4	Physical inactivity
8	Other

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	More than one code can be recorded.

Source and reference attributes

Submitting organisation:	Cardiovascular Data Working Group
Origin:	Smoking, Nutrition, Alcohol, Physical Activity (SNAP) Framework - Commonwealth Department of Health and Ageing - June 2001. Australian Institute of Health and Welfare 2002. Chronic Diseases and associated risk factors in Australians, 2001; Canberra.

Relational attributes

Related metadata references:	Supersedes Behaviour-related risk factor intervention - purpose, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.5 KB)
Implementation in Data Set Specifications:	Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006
	Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007
	Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009
	Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Beta-blocker therapy status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—beta-blocker therapy status, code NN
METeOR identifier:	284802
Registration status:	Health, Standard 04/06/2004
Definition:	The person's beta-blocker therapy status, as represented by a code.
Data Element Concept:	Person—beta-blocker therapy status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
10	Given
21	Not given - patient refusal
22	Not given - allergy or history of intolerance
23	Not given - bradycardia (heart rate less than 50 beats per minute)
24	Not given - symptomatic acute heart failure
25	Not given - systolic blood pressure of less than 90 mmHg
26	Not given - PR interval greater than 0.24 seconds
27	Not given - second and third degree heart block or bifascicular heart block
28	Not given - asthma/airways hyper-reactivity
29	Not given - other

Supplementary values:

Value	Meaning
90	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODES 15 - 29 Not given

If recording 'Not given', record the principal reason if more than one code applies.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Beta-blocker therapy status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008
	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Birth order

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth—birth order, code N
METeOR identifier:	269992
Registration status:	Health, Standard 01/03/2005
Definition:	The sequential order of each baby of a multiple birth, as represented by a code.
Data Element Concept:	Birth—birth order

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
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

Supplementary values:

9	Not stated

Data element attributes

Collection and usage attributes

Guide for use:	CODE 2 Second of a multiple birth Stillborns are counted such that, if twins were born, the first stillborn and the second live-born, the second twin would be recorded as code 2 Second of a multiple birth (and not code 1 Singleton or first of a multiple birth).
Collection methods:	This data should be collected routinely for persons aged 28 days or less.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee Standards Australia

Relational attributes

Related metadata references:

Supersedes Birth order, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.9 KB)

Implementation in Data Set Specifications:

Health care client identification Health, Superseded 04/05/2005

Health care client identification DSS Health, Superseded 03/12/2008

Health care client identification DSS Health, Standard 03/12/2008

Perinatal NMDS Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Perinatal NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Perinatal NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Birth plurality

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—birth plurality, code N
Synonymous names:	Multiple birth
METeOR identifier:	269994
Registration status:	Health, Standard 01/03/2005
Definition:	The number of babies resulting from a single pregnancy, as represented by a code.
Data Element Concept:	Birth event—birth plurality

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Singleton
2	Twins
3	Triplets
4	Quadruplets
5	Quintuplets
6	Sextuplets
8	Other

Supplementary values:

9	Not stated

Data element attributes

Collection and usage attributes

Guide for use:	Plurality of a pregnancy is determined by the number of live births or by the number of fetuses 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 fetuses weighing 400 g or more, are taken into account in determining plurality. Fetuses aborted before 20 completed weeks or fetuses compressed in the placenta at 20 or more weeks are excluded.
Collection methods:	This data should be collected routinely for persons aged 28 days or less.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Birth plurality, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.6 KB)

Implementation in Data Set Specifications:

Health care client identification Health, Superseded 04/05/2005

Health care client identification DSS Health, Superseded 03/12/2008

Health care client identification DSS Health, Standard 03/12/2008

Perinatal NMDS Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Perinatal NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Perinatal NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Bleeding episode using TIMI criteria (status)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—bleeding episode status, Thrombolysis in Myocardial Infarction (TIMI) code N
METeOR identifier:	356725
Registration status:	Health, Standard 01/10/2008
Definition:	A person's episode of bleeding as described by the Thrombolysis In Myocardial Infarction (TIMI) criteria, as represented by a code.
Data Element Concept:	Person—bleeding episode status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Major
2	Minor
3	Non TIMI bleeding

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Note in calculating the fall in haemoglobin or haematocrit, transfusion of whole blood or packed red blood cells is counted as 1g/dl (0.1g/l) haemoglobin or 3% absolute haematocrit.

CODE 1 Major

Overt clinical bleeding (or documented intracranial or retroperitoneal haemorrhage) associated with a drop in haemoglobin of greater than 5g/dl (0.5g/l) or a haematocrit of greater than 15% (absolute).

CODE 2 Minor

Overt clinical bleeding associated with a fall in haemoglobin of 3 or less than or equal to 5g/dl (0.5g/l) or a haematocrit of 9% to less than or equal to 15% (absolute).

CODE 3 Non TIMI Bleeding

Bleeding event that does not meet the major or minor definition.

Data element attributes

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Origin:	Rao AK, Pratt C, Berke A, et al. Thrombolysis in Myocardial Infarction (TIMI) Trial, phase I: hemorrhagic manifestations and changes in plasma fibrinogen and the fibrinolytic system in patients with recombinant tissue plasminogen activator and streptokinase. J Am Coll Cardiol 1988; 11:1-11.

Relational attributes

Related metadata references:	See also Person with acute coronary syndrome—bleeding location, instrumented code N(N) Health, Standard 01/10/2008 Supersedes Person—bleeding episode status, code N Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Blindness (diabetes complication)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—blindness, code N
METeOR identifier:	270065
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the individual has become legally blind in either or both eyes, as represented by a code.
Data Element Concept:	Person—blindness

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Blindness - (
	2	Blindness - (
	3	Blindness - (
	4	No blindness
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 3 Blindness - (< 6/60) occurred in one eye within 12 months and in the other eye prior to the last 12 months Blindness can be diagnosed in one eye within 12 months even though it has been previously diagnosed on the other eye.
Collection methods:	Ask the individual if he/she has been diagnosed as legally blind (< 6/60) in both or either eye. If so record whether it has occurred within or prior to the last 12 months. Alternatively determine blindness from appropriate documentation obtained from an ophthalmologist or optometrist.

Data element attributes

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:	Supersedes Blindness - diabetes complication, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (19.7 KB)
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Superseded 21/09/2005
	Diabetes (clinical) DSS Health, Standard 21/09/2005

Blood pressure—diastolic (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—blood pressure (diastolic) (measured), millimetres of mercury NN[N]
METeOR identifier:	270072
Registration status:	Health, Standard 01/03/2005
Definition:	The person's diastolic **blood pressure,** measured in millimetres of mercury (mmHg).
Data Element Concept:	Person—blood pressure (diastolic)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NN[N]
Maximum character length:	3

Supplementary values:

Value	Meaning
999	Not stated/inadequately described

Unit of measure: Millimetre of mercury (mmHg)

Data element attributes

Collection and usage attributes

Guide for use:

The diastolic pressure is recorded as phase V Korotkoff (disappearance of sound) however phase IV Korotkoff (muffling of sound) is used if the sound continues towards zero but does not cease.

If Blood pressure - diastolic is not collected or not able to be collected, code 999.

Collection methods:

Measurement protocol for resting blood pressure:

The diastolic blood pressure is one component of a routine blood pressure measurement (i.e. systolic/diastolic) and reflects the minimum pressure to which the arteries are exposed.

- The patient should be relaxed and seated, preferably for several minutes, (at least 5 minutes). Ideally, patients should not take caffeine-containing beverages or smoke for two hours before blood pressure is measured.
- Ideally, patients should not exercise within half an hour of the measurement being taken (National Nutrition Survey User's Guide).
- Use a mercury sphygmomanometer. All other sphygmomanometers should be calibrated regularly against mercury sphygmomanometers to ensure accuracy.

- Bladder length should be at least 80%, and width at least 40% of the circumference of the mid-upper arm. If the velcro on the cuff is not totally attached, the cuff is probably too small.
- Wrap cuff snugly around upper arm, with the centre of the bladder of the cuff positioned over the brachial artery and the lower border of the cuff about 2 cm above the bend of the elbow.
- Ensure cuff is at heart level, whatever the position of the patient.
- Palpate the radial pulse of the arm in which the blood pressure is being measured.
- Inflate cuff to the pressure at which the radial pulse disappears and note this value. Deflate cuff, wait 30 seconds, and then inflate cuff to 30 mm Hg above the pressure at which the radial pulse disappeared.
- Deflate the cuff at a rate of 2-3 mm Hg/beat (2-3 mm Hg/sec) or less.
- Recording the diastolic pressure use phase V Korotkoff (disappearance of sound). Use phase IV Korotkoff (muffling of sound) only if sound continues towards zero but does not cease. Wait 30 seconds before repeating the procedure in the same arm. Average the readings.
- If the first two readings differ by more than 4 mmHg diastolic or if initial readings are high, take several readings after five minutes of quiet rest.

Comments:

The pressure head is the height difference a pressure can raise a fluid's equilibrium level above the surface subjected to pressure. (Blood pressure is usually measured as a head of Mercury, and this is the unit of measure nominated for this metadata item.)

The current (2002) definition of hypertension is based on the level of blood pressure above which treatment is recommended, and this depends on the presence of other risk factors, e.g. age, diabetes etc. (NHF 1999 Guide to Management of Hypertension).

Source and reference attributes

Submitting organisation:

Cardiovascular Data Working Group

National Diabetes Data Working Group

Origin:

The National Heart Foundation Blood Pressure Advisory Committee's 'Guidelines for the Management of Hypertension - 1999' which are largely based on World Health Organization Recommendations. (Guidelines Subcommittee of the WHO-ISH: 1999 WHO-ISH guidelines for management of hypertension. J Hypertension 1999; 17:151-83).

Australian Bureau of Statistics 1998. National Nutrition Survey User's Guide 1995. Cat. No. 4801.0. Canberra: ABS. (p. 20).

National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Reference documents:

'Guidelines for the Management of Hypertension - 1999' largely based on World Health Organization Recommendations. (Guidelines Subcommittee of the WHO) J Hypertension 1999; 17: 151-83.).

Diabetes Control and Complications Trial: DCCT New England Journal of Medicine, 329(14), September 30, 1993.

UKPDS 38 Tight blood pressure control and risk of macrovascular and microvascular complications in type 2 diabetes: UK Prospective Diabetes Study Group. British Medical Journal (1998); 317: 703-713.

Relational attributes

Related metadata references:

Supersedes Blood pressure - diastolic measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (26.3 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Blood pressure—systolic (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—blood pressure (systolic) (measured), millimetres of mercury NN[N]
METeOR identifier:	270073
Registration status:	Health, Standard 01/03/2005
Definition:	The person's systolic **blood pressure,** measured in millimetres of mercury (mmHg).
Data Element Concept:	Person—blood pressure (systolic)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NN[N]
Maximum character length:	3

Supplementary values:

Value	Meaning
999	Not stated/inadequately described

Unit of measure: Millimetre of mercury (mmHg)

Data element attributes

Collection and usage attributes

Guide for use: For recording the systolic reading, use phase I Korotkoff (the first appearance of sound). If Blood pressure - systolic is not collected or not able to be collected, code 999.

Collection methods: Measurement protocol for resting blood pressure:

The systolic blood pressure is one component of a routine blood pressure measurement (i.e. systolic/diastolic) and reflects the maximum pressure to which the arteries are exposed.

- The patient should be relaxed and seated, preferably for several minutes, (at least 5 minutes). Ideally, patients should not take caffeine-containing beverages or smoke for two hours before blood pressure is measured.
- Ideally, patients should not exercise within half an hour of the measurement being taken (National Nutrition Survey User's Guide).
- Use a mercury sphygmomanometer. All other sphygmomanometers should be calibrated regularly against mercury sphygmomanometers to ensure accuracy.
- Bladder length should be at least 80%, and width at least 40% of the circumference of the mid-upper arm. If the Velcro on the cuff is not totally attached, the cuff is probably too small.

- Wrap cuff snugly around upper arm, with the centre of the bladder of the cuff positioned over the brachial artery and the lower border of the cuff about 2 cm above the bend of the elbow.
- Ensure cuff is at heart level, whatever the position of the patient.
- Palpate the radial pulse of the arm in which the blood pressure is being measured.
- Inflate cuff to the pressure at which the radial pulse disappears and note this value. Deflate cuff, wait 30 seconds, and then inflate cuff to 30 mm Hg above the pressure at which the radial pulse disappeared.
- Deflate the cuff at a rate of 2-3 mm Hg/beat (2-3 mm Hg/sec) or less.
- For recording the systolic reading, use phase I Korotkoff (the first appearance of sound). Wait 30 seconds before repeating the procedure in the same arm. Average the readings. If the first two readings differ by more than 6 mm Hg systolic or if initial readings are high, take several readings after five minutes of quiet rest.

Comments:

The pressure head is the height difference a pressure can raise a fluid's equilibrium level above the surface subjected to pressure. (Blood pressure is usually measured as a head of Mercury, and this is the unit of measure nominated for this metadata item.)

The current (2002) definition of hypertension is based on the level of blood pressure above which treatment is recommended, and this depends on the presence of other risk factors, e.g. age, diabetes etc. (NHF 1999 Guide to Management of Hypertension).

Source and reference attributes

Submitting organisation:

Cardiovascular Data Working Group

National Diabetes Data Working Group

Origin:

The National Heart Foundation Blood Pressure Advisory Committee's 'Guidelines for the Management of Hypertension - 1999' which are largely based on World Health Organization Recommendations. (Guidelines Subcommittee of the WHO-SH: 1999 WHO-ISH guidelines for management of hypertension. J Hypertension 1999; 17:151-83).

Australian Bureau of Statistics 1998. National Nutrition Survey User's Guide 1995. Cat. No. 4801.0. Canberra: ABS. (p. 20).

National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Reference documents:

'Guidelines for the Management of Hypertension - 1999' largely based on World Health Organization Recommendations. (Guidelines Subcommittee of the WHO) J Hypertension 1999; 17: 151-83.).

Diabetes Control and Complications Trial: DCCT New England Journal of Medicine, 329(14), September 30, 1993.

UKPDS 38 Tight blood pressure control and risk of

macrovascular and microvascular complications in type 2 diabetes: UK Prospective Diabetes Study Group. British Medical Journal (1998); 317: 703-713.

Relational attributes

Related metadata references:

Supersedes Blood pressure - systolic measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (25.9 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Bodily location of main injury

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—bodily location of main injury, code NN
METeOR identifier:	268943
Registration status:	Health, Standard 01/03/2005
Definition:	The bodily location of the injury chiefly responsible for the attendance of the person at the health care facility, as represented by a code.
Data Element Concept:	Person—bodily location of main injury

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Head (excludes face)
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

Data element attributes

Collection and usage attributes

Guide for use:

If the full International Classification of Diseases - Tenth Revision - Australian Modification code is used to code the injury, this metadata item is not required (see metadata items Principal diagnosis and Additional diagnosis.

If any code from 01 to 12 or 26 to 29 in the metadata item Nature of main injury has been selected, the body region affected by that injury must be specified.

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 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).

Comments:

The injury diagnosis is necessary for purposes including epidemiological research, casemix studies and planning. The nature of main injury together with the bodily location of the main injury indicates the diagnosis.

This metadata 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 metadata item Principal diagnosis is not available in most settings where basic injury surveillance is undertaken. This metadata item, in combination with the metadata item Nature 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.

Source and reference attributes

Submitting organisation:

National Injury Surveillance Unit, Flinders University, Adelaide

National Data Standards for Injury Surveillance Advisory Group

Relational attributes

Related metadata references:

See also Injury event—nature of main injury, non-admitted patient code NN{.N} Health, Standard 01/03/2005

Supersedes Bodily location of main injury, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.5 KB)

Implementation in Data Set Specifications:

Injury surveillance DSS Health, Superseded 05/02/2008

Injury surveillance DSS Health, Superseded 14/12/2009

Injury surveillance DSS Health, Standard 14/12/2009

Injury surveillance NMDS Health, Superseded 03/05/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Injury surveillance NMDS Health, Superseded 07/12/2005

Body function

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—body function, code (ICF 2001) AN[NNNN]
Synonymous names:	Body function code
METeOR identifier:	320141
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The physiological or psychological function of a person's body system, as represented by a code.
Data Element Concept:	Person—body function

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Functioning, Disability and Health 2001
Representation class:	Code
Data type:	String
Format:	AN[NNNN]
Maximum character length:	6

Collection and usage attributes

Guide for use:

This metadata item contributes to the definition of the concept '**Disability**' and gives an indication of the experience of disability for a person.

Data can be collected at the three digit level in one chapter and at the chapter level in another. However it is only possible to collect data at a single level of the hierarchy in a single chapter to maintain mutual exclusivity. For example, it is not permitted to collect both Exercise tolerance functions (3 digit level) and 'fatigability' (4-digit level) as the former includes the latter.

The value domain below refers to the highest hierarchical level (ICF chapter level). Data collected at this level, in association with *Impairment extent code N* will use the codes as indicated.

CODE b1 Mental functions
CODE b2 Sensory functions and pain
CODE b3 Voice and speech functions
CODE b4 Functions of the cardiovascular, haematological, immunological and respiratory systems
CODE b5 Functions of the digestive, metabolic and the endocrine system
CODE b6 Genitourinary and reproductive functions
CODE b7 Neuromusculoskeletal and movement-related functions
CODE b8 Functions of the skin and related structures

Data collected at this level will provide a general description of the structures and can only be compared with data collected at the same level.

Each chapter contains categories at different levels ordered from general to detailed. For more detailed information the user should follow the structure of the ICF; the codes should be drawn from the same hierarchical level within any particular chapter. The full range of permissible values together, with definitions is listed in the *Body Functions* component of the ICF.

An example of a value domain at the 3 digit level from the Sensory functions and pain chapter may include:

CODE b210 Seeing functions
CODE b230 Hearing functions
CODE b235 Vestibular functions
CODE b250 Taste functions
CODE b255 Smell functions
CODE b260 Proprioceptive functions
CODE b265 Touch functions
CODE b270 Sensory functions related to temperature and other stimuli
CODE b279 Additional sensory functions, other specified and unspecified

An example of a value domain at the 4 digit level from the body function component may include:

CODE b1300 Energy level
CODE b1400 Sustaining attention
CODE b1442 Retrieval of memory
CODE b1521 Regulation of emotion
CODE b1641 Organization and planning

The prefix ***b*** denotes the domains within the component of *Body Functions.*

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin: WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents: Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website http://www.who.int/classifications/icf/en/
- Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.cfm

Data element attributes

Collection and usage attributes

Guide for use:

This data element can be used to record positive or neutral body function, as well as impairment of body function when used in conjunction with the metadata item Person—extent of impairment of body function, code (ICF 2001)N.

Where multiple body functions or impairments of body functions are recorded, the following prioritising system should be useful.

- The first recorded body function or impairment of body function is the one having the greatest impact on the individual.
- Second and subsequent body function or impairment of body function is also of relevance to the individual.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references:

See also Person—extent of impairment of body function, code (ICF 2001) N Health, Standard 29/11/2006, Community services, Standard 16/10/2006

Implementation in Data Set Specifications:

Body functions cluster Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Body mass index—adult (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Adult—body mass index (measured), ratio NN[N].N[N]
METeOR identifier:	270084
Registration status:	Health, Standard 01/03/2005
Definition:	A measure of an adult's weight (body mass) relative to height used to assess the extent of weight deficit or excess where height and weight have been measured.
Data Element Concept:	Adult—body mass index

Value domain attributes

Representational attributes

Representation class:	Ratio
Data type:	Number
Format:	NN[N].N[N]
Maximum character length:	5

Supplementary values:

Value	Meaning
888.8	Unknown
999.9	Not reported

Data element attributes

Collection and usage attributes

Guide for use:

Formula: BMI = weight (kg) divided by height (m) squared.

Body mass index is a continuous variable.

Code body mass index to one or two decimal places (i.e. 99.99 or 99.9). If any component necessary for its calculation (i.e. weight or height for adults) is unknown or has not been collected, code to 888.8, 999.9.

Collection methods:

NN.NN for BMI calculated from measured height and weight.

BMI should be derived after 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.

Comments:

This metadata item applies to persons aged 2 years or older. It is recommended for use in population surveys and health care settings for adults and population surveys only for children and adolescents. It is recommended that calculated BMI for children and adolescents be compared with a suitable growth reference such as the United States Centers for Disease Control 2000 BMI-for-age chart be used for in health care settings such as hospitals, clinics and in general practice. A BMI greater than the 85th percentile would be classified as overweight, while a BMI greater

than the 95th percentile would be classified as obese. These percentiles are arbitrary and do not relate to morbidity as the BMI cut-points do in adults.

BMI is relatively easy to determine, and has been validated against more direct measures of adiposity such as Magnetic Resonance Imaging and Dual X-ray Absorptiometry.

BMI is a low cost technique, with low respondent and investigator burden. In addition, it offers low inter-observer and intra-observer error, therefore offering good reliability.

Overweight and obesity, as defined by the World Health Organisation (WHO) for the interpretation of BMI (WHO 2000), are exceedingly common in Australia and their prevalence is increasing.

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 metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

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, however for children and adolescents, self-reported or parentally reported data should be used cautiously if at all.

For adults, 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. As such, both BMI and a measure of fat distribution (waist circumference or waist: hip ratio) are important in calculating the risk of obesity comorbidities.

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.

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.

Source and reference attributes

Submitting organisation: The Commonwealth Department of Health and Ageing based on the work of the consortium to develop an Australian standard definition of child/adolescent overweight and obesity; based at the Children Hospital at Westmead.

Origin: Obesity: Preventing and Managing the Global Epidemic. Report of a WHO Consultation. 2000. World Health Organization.

Relational attributes

Related metadata references: See also Person—body mass index (classification), code N[.N] Health, Standard 01/03/2005

Supersedes Body mass index, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (25.7 KB)

Is formed using Person—height (measured), total centimetres NN[N].N Health, Standard 01/03/2005

Is formed using Person—weight (measured), total kilograms N[NN].N Health, Standard 01/03/2005

Body mass index—adult (self-reported)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Adult—body mass index (self-reported), ratio NN[N].N[N]
METeOR identifier:	270086
Registration status:	Health, Standard 01/03/2005
Definition:	A measure of an adult's weight (body mass) relative to height used to assess the extent of weight deficit or excess where at least one of the measures is self reported.
Data Element Concept:	Adult—body mass index

Value domain attributes

Representational attributes

Representation class:	Ratio
Data type:	Number
Format:	NN[N].N[N]
Maximum character length:	5

Supplementary values:

Value	Meaning
888.8	Unknown
999.9	Not reported

Data element attributes

Collection and usage attributes

Collection methods:

NN.N for BMI calculated from either 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. Self-reported or parentally reported height and weight for children and adolescents should be used cautiously if at all.

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.

Comments:

This metadata item applies to persons aged 2 years or older. It is recommended for use in population surveys and health care settings for adults and population surveys only for children and adolescents. It is recommended that calculated BMI for children and adolescents be compared with a suitable growth reference such as the United States Centers for Disease Control 2000 BMI-for-age chart be used for in health care settings such as hospitals, clinics and in general practice. A BMI greater than the 85th

percentile would be classified as overweight, while a BMI greater than the 95th percentile would be classified as obese. These percentiles are arbitrary and do not relate to morbidity as the BMI cut-points do in adults.

BMI is relatively easy to determine, and has been validated against more direct measures of adiposity such as Magnetic Resonance Imaging and Dual X-ray Absorptiometry.

BMI is a low cost technique, with low respondent and investigator burden. In addition, it offers low inter-observer and intra-observer error, therefore offering good reliability.

Overweight and obesity, as defined by the World Health Organisation (WHO) for the interpretation of BMI (WHO 2000), are exceedingly common in Australia and their prevalence is increasing.

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 metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

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, however for children and adolescents, self-reported or parentally reported data should be used cautiously if at all.

For adults, 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. As such, both BMI and a measure of fat distribution (waist circumference or waist: hip ratio) are important in calculating the risk of obesity comorbidities.

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.

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.

Source and reference attributes

Submitting organisation: The Commonwealth Department of Health and Ageing based on the work of the consortium to develop an Australian standard definition of child/adolescent overweight and obesity; based at the Children Hospital at Westmead.

Origin: Obesity: Preventing and Managing the Global Epidemic. Report of a WHO Consultation. 2000. World Health Organization.

Relational attributes

Related metadata references:

See also Person—body mass index (classification), code N[.N] Health, Standard 01/03/2005

Is formed using Person—weight (measured), total kilograms N[NN].N Health, Standard 01/03/2005

Is formed using Person—height (self-reported), total centimetres NN[N] Health, Standard 01/03/2005

Is formed using Person—height (measured), total centimetres NN[N].N Health, Standard 01/03/2005

Supersedes Body mass index, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (25.7 KB)

Is formed using Person—weight (self-reported), total kilograms NN[N] Health, Standard 14/07/2005

Body mass index—child (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Child—body mass index (measured), ratio NN[N].N[N]
METeOR identifier:	270085
Registration status:	Health, Standard 01/03/2005
Definition:	A measure of a child's weight (body mass) relative to height used to assess the extent of weight excess where height and weight have been measured.
Data Element Concept:	Child—body mass index

Value domain attributes

Representational attributes

Representation class:	Ratio
Data type:	Number
Format:	NN[N].N[N]
Maximum character length:	5

Supplementary values:

Value	Meaning
888.8	Unknown
999.9	Not reported

Data element attributes

Collection and usage attributes

Collection methods:

NN.NN for BMI calculated from measured height and weight.

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.

Comments:

This metadata item applies to persons aged 2 years or older. It is recommended for use in population surveys and health care settings for adults and population surveys only for children and adolescents. It is recommended that calculated BMI for children and adolescents be compared with a suitable growth reference such as the United States Centers for Disease Control 2000 BMI-for-age chart be used for in health care settings such as hospitals, clinics and in general practice. A BMI greater than the 85th percentile would be classified as overweight, while a BMI greater than the 95th percentile would be classified as obese. These percentiles are arbitrary and do not relate to morbidity as the BMI cut-points do in adults.

BMI is relatively easy to determine, and has been validated against more direct measures of adiposity such as Magnetic Resonance Imaging and Dual X-ray Absorptiometry.

BMI is a low cost technique, with low respondent and investigator burden. In addition, it offers low inter-observer and intra-observer error, therefore offering good reliability.

Overweight and obesity, as defined by the World Health Organisation (WHO) for the interpretation of BMI (WHO 2000), are exceedingly common in Australia and their prevalence is increasing.

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 metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

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, however for children and adolescents, self-reported or parentally reported data should be used cautiously if at all.

For adults, 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. As such, both BMI and a measure of fat distribution (waist circumference or waist: hip ratio) are important in calculating the risk of obesity comorbidities.

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.

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.

Source and reference attributes

Submitting organisation: The Commonwealth Department of Health and Ageing based on the work of the consortium to develop an Australian standard definition of child/adolescent overweight and obesity; based at the Children Hospital at Westmead.

Origin: Obesity: Preventing and Managing the Global Epidemic. Report of a WHO Consultation. 2000. World Health Organization.

Cole TJ, Bellizi MC, Flegal KM, Bietz WH. Establishing a standard definition for child overweight and obesity worldwide: international survey. British Medical Journal 2000; 320: 1240-1243

Relational attributes

Related metadata references: See also Person—body mass index (classification), code N[.N] Health, Standard 01/03/2005

Supersedes Body mass index, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (25.7 KB)

Is formed using Person—height (measured), total centimetres NN[N].N Health, Standard 01/03/2005

Is formed using Person—weight (measured), total kilograms N[NN].N Health, Standard 01/03/2005

Body mass index—child (self-reported)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Child—body mass index (self-reported), ratio NN[N].N[N]
METeOR identifier:	270087
Registration status:	Health, Standard 01/03/2005
Definition:	A measure of a child's weight (body mass) relative to height used to assess the extent of weight excess where at least one of the measures is self reported.
Data Element Concept:	Child—body mass index

Value domain attributes

Representational attributes

Representation class:	Ratio
Data type:	Number
Format:	NN[N].N[N]
Maximum character length:	5

Supplementary values:

Value	Meaning
888.8	Unknown
999.9	Not reported

Data element attributes

Collection and usage attributes

Collection methods:

NN.N for BMI calculated from either 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. Self-reported or parentally reported height and weight for children and adolescents should be used cautiously if at all.

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.

Comments:

This metadata item applies to persons aged 2 years or older. It is recommended for use in population surveys and health care settings for adults and population surveys only for children and adolescents. It is recommended that calculated BMI for children and adolescents be compared with a suitable growth reference such as the United States Centers for Disease Control 2000 BMI-for-age chart be used for in health care settings such as hospitals, clinics and in general practice. A BMI greater than the 85th

percentile would be classified as overweight, while a BMI greater than the 95th percentile would be classified as obese. These percentiles are arbitrary and do not relate to morbidity as the BMI cut-points do in adults.

BMI is relatively easy to determine, and has been validated against more direct measures of adiposity such as Magnetic Resonance Imaging and Dual X-ray Absorptiometry.

BMI is a low cost technique, with low respondent and investigator burden. In addition, it offers low inter-observer and intra-observer error, therefore offering good reliability.

Overweight and obesity, as defined by the World Health Organisation (WHO) for the interpretation of BMI (WHO 2000), are exceedingly common in Australia and their prevalence is increasing.

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 metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

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, however for children and adolescents, self-reported or parentally reported data should be used cautiously if at all.

For adults, 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. As such, both BMI and a measure of fat distribution (waist circumference or waist: hip ratio) are important in calculating the risk of obesity comorbidities.

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.

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.

Source and reference attributes

Submitting organisation: The Commonwealth Department of Health and Ageing based on the work of the consortium to develop an Australian standard definition of child/adolescent overweight and obesity; based at the Children Hospital at Westmead.

Origin: Obesity: Preventing and Managing the Global Epidemic. Report of a WHO Consultation. 2000. World Health Organization.

Cole TJ, Bellizi MC, Flegal KM, Bietz WH. Establishing a standard definition for child overweight and obesity worldwide: international survey. British Medical Journal 2000; 320: 1240-1243

Relational attributes

Related metadata references: Supersedes Body mass index, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (25.7 KB)

Is formed using Person—height (measured), total centimetres NN[N].N Health, Standard 01/03/2005

Is formed using Person—height (self-reported), total centimetres NN[N] Health, Standard 01/03/2005

Is formed using Person—weight (measured), total kilograms N[NN].N Health, Standard 01/03/2005

See also Person—body mass index (classification), code N[.N] Health, Standard 01/03/2005

Is formed using Person—weight (self-reported), total kilograms NN[N] Health, Standard 14/07/2005

Body mass index—classification

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—body mass index (classification), code N[.N]
METeOR identifier:	270474
Registration status:	Health, Standard 01/03/2005
Data Element Concept:	Person—body mass index (classification)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[.N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	Not overweight or obese
1.1	Underweight
1.2	Normal range 18.50 - 24.99 Average
2	Overweight >= 25.00 Average
2.1	Overweight >= 25.0 Average
2.2	Pre Obese 25.00 - 29.99 Increased
3	Obese >= 30 Increased
3.1	Obese class 1 30.00 - 34.99 Moderate
3.2	Obese class 2 35.00 - 39.99 Severe
3.3	Obese class 3 >= 40.00 Very severe

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Adults:

Body mass index for adults cannot be calculated if components necessary for its calculation (weight or height) is unknown or has not been collected (i.e. is coded to 888.8 or 999.9).

BMI for adults is categorised according to the range it falls within as indicated by codes 1.1, 1.2, 2.1, 2.2, 3.1, 3.2, 3.3 or 9.9. For consistency, when the sample includes children and adolescents, adults can be analysed under the broader categories of 1, 2, 3 or 9 as used for categorising children and adolescents.

Children/adolescents:

Body mass index for children and adolescents aged 2 to 17 years cannot be calculated if components necessary for its calculation (date of birth, sex, weight or height) is unknown or has not been collected (i.e. is coded to 888.8, 999.9 or 9).

Self-reported or parentally reported height and weight for children and adolescents should be used cautiously if at all.

To determine overweight and obesity in children and adolescents, compare the derived BMI against those recorded for the relevant age and sex of the subject to be classified, against Table 1: Classification of BMI for children and adolescents, based on BMI cut-points developed by Cole et al (see below). For example, an 11 year old boy with a BMI of 21 would be considered overweight (i.e. coded as 2), or a 7 year old girl with a BMI of 17.5 would be considered not overweight or obese (i.e. coded as 1).

Using this method, children and adolescents can only be coded as 1, 2, 3 or 9.

Collection methods:

Use N for BMI category determined (1, 2, 3 or 9) for persons (children and adolescents) aged 2 to 17 years.

Use N.N for BMI category determined (1.1, 1.2, 2.1, 2.2, 3.1, 3.2, 3.3 or 9.9) for persons aged 18 years or older.

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 public health policy .

Data element attributes

Collection and usage attributes

Guide for use:

Table 1: Classification of overweight and obesity for children and adolescents

Age(years)	BMI equivalent to 25 kg/m2		BMI equivalent to 30 kg/m2	
	Males	Females	Males	Females
2	18.41	18.02	20.09	19.81
2.5	18.13	17.76	19.80	19.55
3	17.89	17.56	19.57	19.36
3.5	17.69	17.40	19.39	19.23
4	17.55	17.28	19.29	19.15
4.5	17.47	17.19	19.26	19.12
5	17.42	17.15	19.30	19.17
5.5	17.45	17.20	19.47	19.34
6	17.55	17.34	19.78	19.65
6.5	17.71	17.53	20.23	20.08
7	17.92	17.75	20.63	20.51
7.5	18.16	18.03	21.09	21.01
8	18.44	18.35	21.60	21.57
8.5	18.76	18.69	22.17	22.18

9	19.10	19.07	22.77	22.81
9.5	19.46	19.45	23.39	23.46
10	19.84	19.86	24.00	24.11
10.5	20.20	20.29	24.57	24.77
11	20.55	20.74	25.10	25.42
11.5	20.89	21.20	25.58	26.05
12	21.22	21.68	26.02	26.67
12.5	21.56	22.14	26.43	27.24
13	21.91	22.58	26.84	27.76
13.5	22.27	22.98	27.25	28.20
14	22.62	23.34	27.63	28.57
14.5	22.96	23.66	27.98	28.87
15	23.29	23.94	28.30	29.11
15.5	23.60	24.17	28.60	29.29
16	23.90	24.37	28.88	29.43
16.5	24.19	24.54	29.14	29.56
17	24.46	24.70	29.41	26.69
17.5	24.73	24.85	29.70	29.84
18	25.00	25.00	30.00	30.00

Comments:

This metadata item applies to persons aged 2 years or older. It is recommended for use in population surveys and health care settings for adults and population surveys only for children and adolescents. It is recommended that calculated BMI for children and adolescents be compared with a suitable growth reference such as the US Centers for Disease Control 2000 BMI- for-age chart in health care settings such as hospitals, clinics and in general practice. A BMI greater than the 85th percentile would be classified as overweight, while a BMI greater than the 95th percentile would be classified as obese. These percentiles are arbitrary and do not relate to morbidity as the BMI cut-points do in adults.

BMI can be considered to provide the most useful, albeit crude, population-level measure of obesity. The robust nature of the measurements and the widespread routine inclusion of weights and heights in clinical and population health surveys mean that a more selective measure of adiposity, such as skinfold thickness measurements, provides additional rather than primary information. BMI can be used to estimate the prevalence of obesity within a population and the risks associated with it, but does not, however, account for the wide variation in the nature of obesity between different individuals and populations (WHO 2000).

BMI values for adults are age-independent and the same for both sexes.

However, BMI values for children and adolescents aged 2 to 17 years are age and sex specific and are classified by comparing

against the above table, Table 1: Classification of BMI for children and adolescents.

For adults and children and adolescents BMI may not correspond to the same degree of fatness in different populations due, in part, to differences in body proportions. The classification table shows a simplistic relationship between BMI and the risk of comorbidity, which can be affected by a range of factors, including the nature of the diet, ethnic group and activity level. The risks associated with increasing BMI are continuous and graded and begin at a BMI of 25 (or equivalent to 25 for children and adolescents). The interpretation of BMI grades in relation to risk may differ for different populations. Both BMI and a measure of fat distribution (waist circumference or waist: hip ratio in adults) are important in calculating the risk of obesity comorbidities.

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 metadata items currently exist for sex, date of birth, country of birth, Indigenous Status and smoking. Metadata items are being developed for physical activity.

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. 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 above.

Source and reference attributes

Submitting organisation: World Health Organization (see also Comments) and the consortium to develop an Australian standard definition of child/adolescent overweight and obesity; at the Children's Hospital at Westmead on behalf of the Commonwealth Department of Health & Ageing

Origin: Obesity: Preventing and Managing the Global Epidemic (Report of a WHO Consultation: World Health Organization 2000);

Cole TJ, Bellizi MC, Flegal KM, Dietz WH. Establishing a

standard definition for child overweight and obesity worldwide: international survey. British Medical Journal 2000; 320: 1240-1243

Relational attributes

Related metadata references:

See also Child—body mass index (measured), ratio NN[N].N[N] Health, Standard 01/03/2005

See also Adult—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005

Supersedes Body mass index - classification, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (79.5 KB)

Body structure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—body structure, code (ICF 2001) AN[NNNN]
Synonymous names:	Body structure code
METeOR identifier:	320147
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	An anatomical part of a person's body such as organs, limbs or their components, as represented by a code.
Data Element Concept:	Person—body structure

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Functioning, Disability and Health 2001
Representation class:	Code
Data type:	String
Format:	AN[NNNN]
Maximum character length:	6

Collection and usage attributes

Guide for use:

This metadata item contributes to the definition of the concept **disability** and gives an indication of the experience of disability for a person.

Data can be collected at the three digit level in one chapter and at the chapter level in another. However it is only possible to collect data at a single level of the hierarchy in a single chapter to maintain mutual exclusivity. For example, it is not permitted to collect both 'Skin and related structures' (chapter level) and 'Structure of nails' (3 digit level) as the former includes the latter.

The value domain below refers to the highest hierarchical level (ICF chapter level). Data collected at this level, in association with respective qualifiers (*Impairment extent code N*, *Impairment nature code N*, *Impairment location code N*) will use the codes as indicated.

CODE s1 Structures of the nervous system
CODE s2 The eye, ear and related structures
CODE s3 Structures involved in voice and speech
CODE s4 Structures of the cardiovascular, immunological and respiratory systems
CODE s5 Structures related to the digestive, metabolic and endocrine systems
CODE s6 Structures related to the genitourinary and reproductive systems
CODE s7 Structures related to movement

CODE s8 Skin and related structures

Data collected at this level will provide a general description of the structures and can only be compared with data collected at the same level.

Each chapter contains categories at different levels ordered from general to detailed. For more detailed information the user should follow the structure of the ICF; the codes should be drawn from the same hierarchical level within any particular chapter. The full range of permissible values together with definitions is listed in the Body Structures component of the ICF.

An example of a value domain at the 3 digit level from the Structures of the nervous system chapter may include:

CODE s110 Structure of the brain
CODE s120 Spinal cord and related structures
CODE s130 Structure of the meninges
CODE s140 Structure of sympathetic nervous system
CODE s150 Structure of parasympathetic nervous system
CODE s198 Structure of the nervous system, other specified
CODE s199 Structure of the nervous system, unspecified

An example of a value domain at the 4 digit level from the Structures related to movement chapter may include:

CODE s7300 Structure of upper arm
CODE s7301 Structure of forearm
CODE s7302 Structure of hand
CODE s7500 Structure of thigh
CODE s7501 Structure of lower leg
CODE s7502 Structure of ankle and foot
CODE s7600 Structure of vertebral column

The prefix ***s*** denotes the domains within the component of *Body Structures*.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin: WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents: Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website http://www.who.int/classifications/icf/en/
- Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.cfm

Data element attributes

Collection and usage attributes

Guide for use:

This data element consists of a single, neutral list of body structures that can be used to record positive or neutral body function. In conjunction with *Impairment extent code N*, it enables the provision of information about the presence and extent of impairment for any given body structures; with *Impairment nature code N*, the provision of information about the nature of the impairment for given body functions; and *Impairment location code N*, the location of the impairment for given body functions.

Where multiple body structures or **impairments of body structures** are recorded, the following prioritising system should be useful:

- The first recorded body structure or impairment of body function is the one having the greatest impact on the individual.
- Second and subsequent body structure or impairment of body function is also of relevance to the individual.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Implementation in Data Set Specifications:

Body structures cluster Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Building/complex sub-unit number (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—building/complex sub-unit identifier, [X(7)]
METeOR identifier:	270018
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	The unique number or identifier for a building/complex, marina, etc. where a person resides.
Data Element Concept:	Person (address)—building/complex sub-unit identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	[X(7)]
Maximum character length:	7

Data element attributes

Collection and usage attributes

Guide for use:	The building/complex sub-unit number must be recorded with its corresponding building/complex unit type - abbreviation. Where applicable, the number may be followed by an alphanumeric suffix.
Collection methods:	To be collected in conjunction with building/complex sub-unit type - abbreviation.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Australia Post Address Presentation Standard
Reference documents:	Australian Standard; Interchange of client information, 4590-2006.

Relational attributes

Related metadata references:	Supersedes Building/complex sub-unit number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB) Is used in the formation of Person (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005 Is used in the formation of Person (address)—health address line, text [X(180)] Health, Superseded 04/05/2005

Implementation in Data Set Specifications:	Health care client identification DSS Health, Superseded 03/12/2008
	Health care client identification DSS Health, Standard 03/12/2008
	Health care provider identification DSS Health, Superseded 04/07/2007
	Health care provider identification DSS Health, Superseded 03/12/2008
	Health care provider identification DSS Health, Standard 03/12/2008

Building/complex sub-unit number (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—building/complex sub-unit identifier, [X(7)]
METeOR identifier:	290291
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The unique number or identifier of a building/complex, marina, etc. where an organisation is located.
Data Element Concept:	Service provider organisation (address)—building/complex sub-unit identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	[X(7)]
Maximum character length:	7

Data element attributes

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Is used in the formation of Service provider organisation (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005
Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007
	Health care provider identification DSS Health, Superseded 03/12/2008
	Health care provider identification DSS Health, Standard 03/12/2008

Building/complex sub-unit type—abbreviation (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—building/complex sub-unit type, code A[AAA]
Synonymous names:	Australian unit type
METeOR identifier:	270023
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	The type of building/complex where a person can be located, as represented by a code.
Data Element Concept:	Person (address)—building/complex sub-unit type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A[AAA]
Maximum character length:	4

Permissible values:

Value	Meaning
APT	Apartment
CTGE	Cottage
DUP	Duplex
FY	Factory
F	Flat
HSE	House
KSK	Kiosk
MSNT	Maisonette
MB	Marine Berth
OFF	Office
PTHS	Penthouse
RM	Room
SHED	Shed
SHOP	Shop
SITE	Site
SL	Stall
STU	Studio
SE	Suite
TNHS	Townhouse
U	Unit

VLLA	Villa
WARD	Ward
WE	Warehouse

Collection and usage attributes

Guide for use:

Addresses may contain multiple instances of building/complex type. Record each instance of building/complex type with its corresponding building/complex number when appropriate.

Examples:

APT 6

SHOP 3A

U 6

PTHS

Data element attributes

Collection and usage attributes

Collection methods:

To be collected in conjunction with building/complex sub unit number.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Origin:

Health Data Standards Committee

Relational attributes

Related metadata references:

Supersedes Building/complex sub-unit type - abbreviation, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.8 KB)

Is used in the formation of Person (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is used in the formation of Person (address)—health address line, text [X(180)] Health, Superseded 04/05/2005

Implementation in Data Set Specifications:

Health care client identification DSS Health, Superseded 03/12/2008

Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Superseded 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Building/complex sub-unit type—abbreviation (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—building/complex sub-unit type, code A[AAA]
METeOR identifier:	290278
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The type of building/complex where an organisation can be located, as represented by a code.
Data Element Concept:	Service provider organisation (address)—building/complex sub-unit type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A[AAA]
Maximum character length:	4

Permissible values:

Value	Meaning
APT	Apartment
CTGE	Cottage
DUP	Duplex
FY	Factory
F	Flat
HSE	House
KSK	Kiosk
MSNT	Maisonette
MB	Marine Berth
OFF	Office
PTHS	Penthouse
RM	Room
SHED	Shed
SHOP	Shop
SITE	Site
SL	Stall
STU	Studio
SE	Suite
TNHS	Townhouse

U	Unit
VLLA	Villa
WARD	Ward
WE	Warehouse

Collection and usage attributes

Guide for use:

Addresses may contain multiple instances of building/complex type. Record each instance of building/complex type with its corresponding building/complex number when appropriate.

Examples:

APT 6

SHOP 3A

U 6

PTHS

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Health Data Standards Committee

Relational attributes

Related metadata references:

Is used in the formation of Service provider organisation (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Implementation in Data Set Specifications:

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Superseded 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Building/property name (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—building/property name, text [X(30)]
Synonymous names:	Australian address site name
METeOR identifier:	270028
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	The name of a building or property where a person resides, as represented by text.
Data Element Concept:	Person (address)—building/property name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(30)]
Maximum character length:	30

Data element attributes

Collection and usage attributes

Guide for use:

Usually this information is not abbreviated.

Should include any reference to a wing or other components of a building complex, if applicable.

A comma is to be used to separate the wing reference from the rest of the building name.

Record each Building/property name relevant to the address:

- Building/property name 1 (30 alphanumeric characters)
- Building/property name 2 (30 alphanumeric characters)

For example:

Building - TREASURY BUILDING

Property - BRINDABELLA STATION

Source and reference attributes

Origin:	Health Data Standards Committee Australia Post Address Presentation Standard
Reference documents:	AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

Related metadata references:	Supersedes Building/property name, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.8 KB)
	Is used in the formation of Person (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005
	Is used in the formation of Person (address)—health address line, text [X(180)] Health, Superseded 04/05/2005
Implementation in Data Set Specifications:	Health care client identification DSS Health, Superseded 03/12/2008
	Health care client identification DSS Health, Standard 03/12/2008
	Health care provider identification DSS Health, Superseded 04/07/2007
	Health care provider identification DSS Health, Superseded 03/12/2008
	Health care provider identification DSS Health, Standard 03/12/2008

Building/property name (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—building/property name, text [X(30)]
METeOR identifier:	290295
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The name of a building or property where an organisation is located, as represented by text.
Data Element Concept:	Service provider organisation (address)—building/property name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(30)]
Maximum character length:	30

Data element attributes

Collection and usage attributes

Guide for use:

Usually this information is not abbreviated.

Should include any reference to a wing or other components of a building complex, if applicable.

A comma is to be used to separate the wing reference from the rest of the building name.

Record each Building/property name relevant to the address:

- Building/property name 1 (30 alphanumeric characters)
- Building/property name 2 (30 alphanumeric characters)

For example:

Building - TREASURY BUILDING

Property - BRINDABELLA STATION

Source and reference attributes

Origin:

Health Data Standards Committee

Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Is used in the formation of Service provider organisation (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005
Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007
	Health care provider identification DSS Health, Superseded 03/12/2008
	Health care provider identification DSS Health, Standard 03/12/2008

Bundle-branch block status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Electrocardiogram—bundle-branch block status, code N
METeOR identifier:	343866
Registration status:	Health, Standard 01/10/2008
Definition:	The bundle-branch block status identified on a person's electrocardiogram (ECG), as represented by a code.
Data Element Concept:	Electrocardiogram—bundle-branch block status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	New
2	Pre-existing
3	Uncertain timing

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	To determine the bundle-branch block status, compare the current ECG to the preceding or most recently available ECG.
Collection methods:	Record for each ECG that indicates a bundle-branch block is present. Only one bundle-branch block status can be recorded for each ECG performed. Only one bundle-branch block can occur at any one time, but in any given person, a left bundle-branch block may occur at one time point and a right bundle-branch block at another time point. Therefore, there can only be one bundle-branch block per ECG, but they may differ temporally.

Relational attributes

Implementation in Data Set Specifications:	Electrocardiogram cluster Health, Standard 01/10/2008 *Conditional obligation:* Record if a bundle-branch block has been detected on an electrocardiogram.

C-reactive protein level (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—C-reactive protein level (measured), total milligrams per litre N[NN].N
Synonymous names:	CRP measured
METeOR identifier:	338256
Registration status:	Health, Standard 01/10/2008
Definition:	A person's serum C-reactive protein (CRP) level, measured in milligrams per litre.
Data Element Concept:	Person—C-reactive protein level (measured)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN].N
Maximum character length:	4

Supplementary values:

Value	Meaning
999.9	Not stated/inadequately described

Unit of measure:	Milligram per litre (mg/L)
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Comments: The value should be recorded on a high sensitivity assay.

CRP is used in the assessment of acute phase reaction in inflammatory, infective and neoplastic disorders.

Source and reference attributes

Reference documents: The Royal College of Pathologists of Australia Version 4.0 12th March 2004 (last accessed 12May 2006). http://www.rcpamanual.edu.au/sections/pathologytest.asp?s=33&i=468

Relational attributes

Related metadata references: See also Person—C-reactive protein level measured time, hhmm Health, Standard 01/10/2008

See also Person—C-reactive protein level measured date, DDMMYYYY Health, Standard 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

CVD drug therapy—condition

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—cardiovascular disease condition targeted by drug therapy, code NN
METeOR identifier:	270193
Registration status:	Health, Standard 01/03/2005
Definition:	The condition(s) for which drug therapy is being used for the prevention or long-term treatment of cardiovascular disease, as represented by a code.
Data Element Concept:	Person—cardiovascular disease condition targeted by drug therapy

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Heart failure
02	Ischaemic heart disease
03	Hypertension
04	Atrial fibrillation (AF)
05	Other dysrhythmia or conductive disorder
06	Dyslipidaemia
07	Peripheral vascular disease (PVD)
08	Renal vascular disease
09	Stroke
10	Transient ischaemic attack (TIA)
97	Other
98	No CVD drugs prescribed

Supplementary values:

Value	Meaning
99	Not recorded

Collection and usage attributes

Guide for use:	The categorisations may be made using the most recent version of the Australian Modification of the appropriate International Classification of Diseases codes.

Data element attributes

Collection and usage attributes

Guide for use:	More than one code can be recorded.
Comments:	References such as the Australian Medicines Handbook can be used to identify specific drugs that are appropriate for use in the management of the conditions identified in the value domain.

Source and reference attributes

Submitting organisation:	Cardiovascular Data Working Group

Relational attributes

Related metadata references:	Supersedes CVD drug therapy - condition, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.0 KB)
Implementation in Data Set Specifications:	Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006 Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007 Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009 Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Caesarean section indicator, last previous birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—caesarean section indicator (last previous birth) code N
METeOR identifier:	301993
Registration status:	Health, Standard 29/11/2006
Definition:	Whether a caesarean section was performed for the woman's last previous birth, as represented by a code.
Data Element Concept:	Female—caesarean section indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:	This item should be completed if there has been a previous birth. In the case of no previous births, the item should be left blank.
Comments:	Previous caesarean sections are associated with a higher risk of obstetric complications, and when used with other indicators provides important information on the quality of obstetric care. This item can be used to determine vaginal births occurring after a caesarean section delivery (VBAC).

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Cancer initial treatment completion date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—non-surgical cancer treatment completion date, DDMMYYYY
METeOR identifier:	288136
Registration status:	Health, Standard 04/06/2004
Definition:	The date on which the initial non-surgical treatment for cancer was completed.
Data Element Concept:	Cancer treatment—non-surgical cancer treatment completion date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	Collected for radiation therapy and systemic therapy.

Source and reference attributes

Submitting organisation:	National Cancer Control Initiative
Origin:	Commission on Cancer, American College of Surgeons
Reference documents:	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:	Supersedes Cancer initial treatment - completion date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.6 KB)
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005
	Cancer (clinical) DSS Health, Superseded 06/03/2009
	Cancer (clinical) DSS Health, Superseded 22/12/2009
	Cancer (clinical) DSS Health, Standard 22/12/2009

Cancer initial treatment starting date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—non-surgical cancer treatment start date, DDMMYYYY
METeOR identifier:	288103
Registration status:	Health, Standard 04/06/2004
Definition:	The start date of the initial course of non-surgical treatment for cancer.
Data Element Concept:	Cancer treatment—non-surgical cancer treatment start date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	The start date of the treatment is recorded regardless of whether treatment is completed as intended or not. Treatment subsequent to a recurrence will not be recorded. Collected for radiation therapy and systemic therapy. Date of surgical treatment is collected as a separate item.

Source and reference attributes

Submitting organisation:	National Cancer Control Institute
Origin:	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998).

Relational attributes

Related metadata references:	Supersedes Cancer initial treatment - starting date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Superseded 06/03/2009 Cancer (clinical) DSS Health, Superseded 22/12/2009 Cancer (clinical) DSS Health, Standard 22/12/2009

Cancer staging—M stage code

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—distant metastasis status, M stage (UICC TNM Classification of Malignant Tumours, 6th edn) code XX
METeOR identifier:	341300
Registration status:	Health, Standard 06/03/2009
Definition:	Absence or presence of distant metastasis at the time of diagnosis of the primary cancer, as represented by a code.
Data Element Concept:	Person with cancer—distant metastasis status

Value domain attributes

Representational attributes

Classification scheme:	International Union against Cancer (UICC) TNM Classification of Malignant Tumours 6th edition
Representation class:	Code
Data type:	String
Format:	XX
Maximum character length:	2

Supplementary values:

Value	Meaning
88	Not applicable

Collection and usage attributes

Guide for use: Valid M codes from the current edition of the UICC TNM Classification of Malignant Tumours.

Refer to the TNM Supplement: A Commentary on Uniform Use, 3rd Edition for coding rules.

Data element attributes

Collection and usage attributes

Guide for use: TNM staging applies to solid tumours excluding brain tumours.

Choose the lower (less advanced) M category when there is any uncertainty.

Collection methods: From information provided by the treating doctor and recorded on the patient's medical record.

Comments: Cancer prognosis and survival can be related to the extent of the disease at diagnosis. Survival rates are generally higher if the disease is localised to the organ of origin compared with cases in which the tumour has spread beyond the primary site.

Staging systems seek to classify patients having a similar prognosis into groups or stages. TNM staging is an internationally agreed staging classification system based on the

anatomical site of the primary tumour and its extent of spread. The T component refers to the size of the tumour and whether or not it has spread to surrounding tissues. The N component describes the presence or absence of tumour in regional lymph nodes. The M component refers to the presence or absence of tumour at sites distant from the primary site.

Source and reference attributes

Origin:

International Union Against Cancer (UICC)

Commission on Cancer, American College of Surgeons

Reference documents:

Sobin LH, Wittekind C. TNM Classification of Malignant Tumours. 6th ed. Hoboken, New Jersey: John Wiley & Sons; 2002

Commission on Cancer Facility Oncology Registry Data Standards (FORDS): Revised for 2004

Relational attributes

Related metadata references:

Supersedes Person with cancer—distant metastasis status, M stage (UICC TNM Classification of Malignant Tumours 5th ed) code XX Health, Superseded 06/03/2009

Is used in the formation of Person with cancer—extent of primary cancer, TNM stage (UICC TNM Classification of Malignant Tumours, 6th ed) code XXXX{[X]XX} Health, Standard 06/03/2009

Implementation in Data Set Specifications:

Breast cancer (Cancer registries) DSS Health, Standard 06/03/2009

Cancer (clinical) DSS Health, Superseded 22/12/2009

Conditional obligation:
Collection of this element is conditional on the disease site being listed in the UICC TNM Classification.

Cancer (clinical) DSS Health, Standard 22/12/2009

Conditional obligation:
Collection of this element is conditional on the disease site being listed in the UICC TNM Classification.

Cancer staging—N stage code

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—regional lymph node metastasis status, N stage (UICC TNM Classification of Malignant Tumours, 6th ed) code XX
METeOR identifier:	341302
Registration status:	Health, Standard 06/03/2009
Definition:	Extent of regional lymph node metastasis at the time of diagnosis of the primary cancer, as represented by a code.
Data Element Concept:	Person with cancer—regional lymph node metastasis status

Value domain attributes

Representational attributes

Classification scheme:	International Union against Cancer (UICC) TNM Classification of Malignant Tumours 6th edition
Representation class:	Code
Data type:	String
Format:	XX
Maximum character length:	2

Supplementary values:

Value	Meaning
88	Not applicable

Collection and usage attributes

Guide for use: Valid N codes from the current edition of the UICC TNM Classification of Malignant Tumours.

Refer to the TNM Supplement: A Commentary on Uniform Use, 3rd Edition for coding rules.

Data element attributes

Collection and usage attributes

Guide for use: TNM staging applies to solid tumours excluding brain tumours.

Choose the lower (less advanced) N category when there is any uncertainty.

Collection methods: From information provided by the treating doctor and recorded on the patient's medical record.

Comments: Cancer prognosis and survival can be related to the extent of the disease at diagnosis. Survival rates are generally higher if the disease is localised to the organ of origin compared with cases in which the tumour has spread beyond the primary site.

Staging systems seek to classify patients having a similar prognosis into groups or stages. TNM staging is an

internationally agreed staging classification system based on the anatomical site of the primary tumour and its extent of spread. The T component refers to the size of the tumour and whether or not it has spread to surrounding tissues. The N component describes the presence or absence of tumour in regional lymph nodes. The M component refers to the presence or absence of tumour at sites distant from the primary site.

Source and reference attributes

Reference documents:

Sobin LH, Wittekind C. TNM Classification of Malignant Tumours. 6 ed. Hoboken, New Jersey: John Wiley & Sons; 2002

Commission on Cancer Facility Oncology Registry Data Standards (FORDS): Revised for 2004

Relational attributes

Related metadata references:

Supersedes Person with cancer—regional lymph node metastasis status, N stage (UICC TNM Classification of Malignant Tumours 5th ed) code XX Health, Superseded 06/03/2009

Is used in the formation of Person with cancer—extent of primary cancer, TNM stage (UICC TNM Classification of Malignant Tumours, 6th ed) code XXXX{[X]XX} Health, Standard 06/03/2009

Implementation in Data Set Specifications:

Breast cancer (Cancer registries) DSS Health, Standard 06/03/2009

Cancer (clinical) DSS Health, Superseded 22/12/2009

Conditional obligation:
Collection of this element is conditional on the disease site being listed in the UICC TNM Classification.

Cancer (clinical) DSS Health, Standard 22/12/2009

Conditional obligation:
Collection of this element is conditional on the disease site being listed in the UICC TNM Classification.

Cancer staging—T stage code

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—primary tumour status, T stage (UICC TNM Classification of Malignant Tumours, 6th ed) code XX[X]
METeOR identifier:	341306
Registration status:	Health, Standard 06/03/2009
Definition:	Extent of primary cancer including tumour size, at the time of diagnosis, as represented by a code.
Data Element Concept:	Person with cancer—primary tumour status

Value domain attributes

Representational attributes

Classification scheme:	International Union against Cancer (UICC) TNM Classification of Malignant Tumours 6th edition
Representation class:	Code
Data type:	String
Format:	XX[X]
Maximum character length:	3

Supplementary values:

Value	Meaning
88	Not applicable

Collection and usage attributes

Guide for use: Valid T codes from the current edition of the UICC TNM Classification of Malignant Tumours.

Refer to the TNM Supplement: A Commentary on Uniform Use, 3rd Edition for coding rules.

Data element attributes

Collection and usage attributes

Guide for use: TNM staging applies to solid tumours excluding brain tumours.

Choose the lower (less advanced) T category when there is any uncertainty.

T stage value is derived from value of "Solid tumour size (at diagnosis) total millimetres". Refer to usage attributes for this data element for additional detail.

Collection methods: From information provided by the treating doctor and recorded on the patient's medical record.

Comments: Cancer prognosis and survival can be related to the extent of the disease at diagnosis. Survival rates are generally higher if the disease is localised to the organ of origin compared with cases in which the tumour has spread beyond the primary site.

Staging systems seek to classify patients having a similar prognosis into groups or stages. TNM staging is an internationally agreed staging classification system based on the anatomical site of the primary tumour and its extent of spread. The T component refers to the size of the tumour and whether or not it has spread to surrounding tissues. The N component describes the presence or absence of tumour in regional lymph nodes. The M component refers to the presence or absence of tumour at sites distant from the primary site.

Source and reference attributes

Reference documents:

Sobin LH, Wittekind C. TNM Classification of Malignant Tumours. 6 ed. Hoboken, New Jersey: John Wiley & Sons; 2002

Commission on Cancer Facility Oncology Registry Data Standards (FORDS): Revised for 2004

Relational attributes

Related metadata references:

Is formed using Person with cancer—solid tumour size (at diagnosis), total millimetres NNN Health, Standard 06/03/2009

Supersedes Person with cancer—primary tumour status, T stage (UICC TNM Classification of Malignant Tumours 5th ed) code XX[X] Health, Superseded 06/03/2009

Is used in the formation of Person with cancer—extent of primary cancer, TNM stage (UICC TNM Classification of Malignant Tumours, 6th ed) code XXXX{[X]XX} Health, Standard 06/03/2009

Implementation in Data Set Specifications:

Breast cancer (Cancer registries) DSS Health, Standard 06/03/2009

Cancer (clinical) DSS Health, Superseded 22/12/2009

Conditional obligation:
Collection of this element is conditional on the disease site being listed in the UICC TNM Classification.

Cancer (clinical) DSS Health, Standard 22/12/2009

Conditional obligation:
Collection of this element is conditional on the disease site being listed in the UICC TNM Classification.

Cancer staging—TNM stage grouping code

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—extent of primary cancer, TNM stage (UICC TNM Classification of Malignant Tumours, 6th ed) code XXXX{[X]XX}
METeOR identifier:	341304
Registration status:	Health, Standard 06/03/2009
Definition:	The anatomical extent of disease at diagnosis based on the previously coded T, N and M stage categories, as represented by a code.
Data Element Concept:	Person with cancer—extent of primary cancer

Value domain attributes

Representational attributes

Classification scheme:	International Union against Cancer (UICC) TNM Classification of Malignant Tumours 6th edition
Representation class:	Code
Data type:	String
Format:	XXXX{[X]XX}
Maximum character length:	7

Supplementary values:

Value	Meaning
8888	Not applicable
9999	Unknown, Stage X

Collection and usage attributes

Guide for use:	Valid stage grouping codes from the current edition of the UICC TNM Classification of Malignant Tumours.

Data element attributes

Collection and usage attributes

Guide for use:	TNM staging applies to solid tumours excluding brain tumours. Refer to the TNM Supplement: A Commentary on Uniform Use, 3rd Edition for coding rules. Choose the lower (less advanced) T category when there is any uncertainty.
Collection methods:	From information provided by the treating doctor and recorded on the patient's medical record.

Relational attributes

Related metadata references:

Is formed using Person with cancer—primary tumour status, T stage (UICC TNM Classification of Malignant Tumours, 6th ed) code XX[X] Health, Standard 06/03/2009

Is formed using Person with cancer—distant metastasis status, M stage (UICC TNM Classification of Malignant Tumours, 6th edn) code XX Health, Standard 06/03/2009

Is formed using Person with cancer—regional lymph node metastasis status, N stage (UICC TNM Classification of Malignant Tumours, 6th ed) code XX Health, Standard 06/03/2009

Supersedes Person with cancer—extent of primary cancer, TNM stage (UICC TNM Classification of Malignant Tumours 5th ed) code XXXX{[X]XX} Health, Superseded 06/03/2009

Implementation in Data Set Specifications:

Breast cancer (Cancer registries) DSS Health, Standard 06/03/2009

Cancer (clinical) DSS Health, Superseded 22/12/2009

Conditional obligation:
Collection of this element is conditional on the disease site being listed in the UICC TNM Classification.

Cancer (clinical) DSS Health, Standard 22/12/2009

Conditional obligation:
Collection of this element is conditional on the disease site being listed in the UICC TNM Classification.

Cancer treatment type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—cancer treatment type, code N
METeOR identifier:	288185
Registration status:	Health, Standard 04/06/2004
Definition:	The type of treatment for cancer given as initial treatment for the particular patient, as represented by a code.
Data Element Concept:	Cancer treatment—cancer treatment type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
0	No treatment
1	Surgical treatment
2	Radiation therapy
3	Systemic agent therapy
4	Surgical and radiation treatment
5	Surgical treatment and systemic agent treatment
6	Radiation and systemic agent treatment
7	All three treatment types

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Origin:	Commission on Cancer, American College of Surgeons. New South Wales Health Department.
Reference documents:	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998) Public Health Division NSW Clinical Cancer Data Collection for Outcomes and Quality. Data Dictionary Version 1 Sydney NSW Health Dept (2001)

Relational attributes

Related metadata references:	Supersedes Cancer treatment type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB)
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005
	Cancer (clinical) DSS Health, Superseded 06/03/2009
	Cancer (clinical) DSS Health, Superseded 22/12/2009
	Cancer (clinical) DSS Health, Standard 22/12/2009

Cancer treatment—target site (ICD-10-AM)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—target site for cancer treatment, code (ICD-10-AM 7th edn) ANN{.N[N]}
METeOR identifier:	391324
Registration status:	Health, Standard 22/12/2009
Definition:	The site or region which is the target of particular surgical or radiotherapy treatment, as represented by an ICD-10-AM code.
Data Element Concept:	Cancer treatment—target site for cancer treatment

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:	This information is collected for surgical and radiotherapy treatments. Current edition of International Classification of Diseases (ICD-10-AM), Australian Modification, National Centre for Classification in Health, Sydney is used.

Relational attributes

Related metadata references:	Supersedes Cancer treatment—target site for cancer treatment, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Standard 22/12/2009

Cancer treatment—target site (ICDO-3)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—target site for cancer treatment, code (ICDO-3) ANN
METeOR identifier:	293161
Registration status:	Health, Standard 13/06/2004
Definition:	The site or region of cancer which is the target of a particular surgical or radiotherapy treatment, as represented by an ICDO-3 code.
Data Element Concept:	Cancer treatment—target site for cancer treatment

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Diseases for Oncology 3rd edition
Representation class:	Code
Data type:	String
Format:	ANN
Maximum character length:	3

Data element attributes

Collection and usage attributes

Guide for use:	This information is collected for surgical and radiotherapy treatments. Current edition of International Classification of Diseases for Oncology (ICD-O), World Health Organisation is used. Major organ only - first 3 characters.

Relational attributes

Related metadata references:	Supersedes Cancer treatment - target site, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.2 KB)
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Superseded 06/03/2009 Cancer (clinical) DSS Health, Superseded 22/12/2009 Cancer (clinical) DSS Health, Standard 22/12/2009

Capital consumption expenses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Organisation—capital consumption expenses, total Australian currency NNNNN.N
METeOR identifier:	376399
Registration status:	Health, Standard 01/04/2009
Definition:	Expenses of an organisation consisting of consumption of fixed capital (depreciation), in Australian currency.
Data Element Concept:	Organisation—capital consumption expenses

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	NNNNN.N
Maximum character length:	6
Unit of measure:	Australian currency (AU$)

Source and reference attributes

Submitting organisation:	Health Expenditure Advisory Committee

Data element attributes

Collection and usage attributes

Guide for use:	Data are collected and nationally collated for the reporting period - the financial year ending 30th June each year. Depreciation expenses are to be reported in millions to the nearest 100,000 e.g. $4,064,000 should be reported as $4.1 million. When revenue from transactions are offset against expenses from transactions, the result equates to the net operating balance in accordance with Australian Accounting Standards Board 1049 (September 2006). 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.
Collection methods:	Depreciation expenses are to be reported for the *Health industry relevant organisation type* and *Typeof health and health related functions* data elements. *Health industry relevant organisation type*

State and territory health authorities are **NOT** to report the following codes:

Codes 106–109; 111; 115–119; 123; 201 and 203

Type of health and health related functions

State and territory health authorities are **NOT** to report the following codes:

Codes 199; 299; 303–305; 307; 499; 503–504; 599; 601–603; 688; 699

Comments: In accounting terms, expenses are consumptions or losses of future economic benefits in the form of reductions in assets or increases in liabilities of the entity (other than those relating to distributions to owners) that result in a decrease in equity or net worth during the reporting period.

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Origin: Australian Bureau of Statistics: Government Finance Statistics 1998, Cat. No. 5514.0.

Australian Bureau of Statistics 2006. Australian System of Government Finance Statistics: Concepts, sources and methods, 2005. Cat. no. 5514.0.55.001 Canberra: ABS.

Australian Accounting Standards Board 1049, September 2006, <www.aasb.com.au>

Relational attributes

Related metadata references: Supersedes Organisation—depreciation expenses, total Australian currency NNNNN.N Health, Superseded 01/04/2009

Is used in the formation of Organisation—expenses, total Australian currency NNNNN.N Health, Standard 05/12/2007

Implementation in Data Set Specifications: Government health expenditure organisation expenditure capital consumption data element cluster Health, Standard 01/04/2009

Government health expenditure organisation expenditure data element cluster Health, Standard 01/04/2009

Cardiovascular medication (current)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—cardiovascular medication taken (current), code N
METeOR identifier:	270237
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the individual is currently taking cardiovascular medication, as represented by a code.
Data Element Concept:	Person—cardiovascular medication taken

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Angiotensin converting enzyme (ACE) inhibitors
2	Angiotensin II (A2) receptor blockers
3	Beta blockers
4	Calcium antagonists
8	None of the above
Supplementary values: 9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Angiotensin converting enzyme (ACE) inhibitors

Use this code for ACE inhibitors (captopril, enalapril, fosinopril, lisinopril, perindopril, quinapril, ramipril and trandolapril).

CODE 2 Angiotensin II (A2) receptor blockers

Use this code for Angiotensin II receptor blockers (candesartan, eprosartan, irbesartan and telmisartan).

CODE 3 Beta blockers

Use this code for Beta blockers (atenolol, carvedilol, labetalol, metoprolol, oxprenolol, pindolol, propranolol and sotalol).

CODE 4 Calcium antagonists

Use this code for Calcium antagonists (amlodipine, diltiazem, felodipine, lercanidipine, nifedipine and verapamil).

CODE 8 None of the above

This code is used when none of the listed medications is being taken by the person.

CODE 9 Not stated/inadequately described

This code should only be used in situations where it is not practicable to ask the questions.

Collection methods:

The person should be asked a series of questions about any current medication for a cardiovascular condition as follows:

Are you currently taking any medication for a cardiovascular condition?

___Yes ___No

If the person answers 'NO', then code 8 should be applied.

If the person answers 'YES', then ask which one(s) (from the list of drugs in the Guide for use).

Ace Inhibitors ___Yes ___No

Angiotensin II receptor blockers ___Yes ___No

Beta blockers ___Yes ___No

Calcium antagonists ___Yes ___No

The appropriate code should be recorded for each type of medication currently in use.

Data element attributes

Collection and usage attributes

Collection methods:

A person may be taking one or more of the following medications for a cardiovascular condition. Therefore more than one code may be reported.

Source and reference attributes

Origin:

National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary. Australian Medicines Handbook: last modified by February 2001 Contents of Cardiovascular, Version 3, 1999 Therapeutic Guidelines Limited (05.04.2002)].

Relational attributes

Related metadata references:

Supersedes Cardiovascular medication - Superseded 01/03/2005, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.1 KB)

Implementation in Data Set Specifications:

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Care type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Hospital service—care type, code N[N].N
METeOR identifier:	270174
Registration status:	Health, Standard 01/03/2005
Definition:	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), as represented by a code.
Data Element Concept:	Hospital service—care type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N].N
Maximum character length:	3

Permissible values:

Value	Meaning
1.0	Acute care (Admitted care)
2.0	Rehabilitation care (Admitted 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
9.0	Organ procurement - posthumous (Other care)
10.0	Hospital boarder (Other care)

Collection and usage attributes

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:

CODE 1.0 Acute care (Admitted care)

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
- protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function
- perform diagnostic or therapeutic procedures.

CODE 2.0 Rehabilitation care (Admitted care)

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:

CODE 2.1 Rehabilitation care delivered in a designated unit (optional)

A designated rehabilitation care unit 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.

CODE 2.2 Rehabilitation care according to a designated program (optional)

In a designated rehabilitation care program, 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.

CODE 2.3 Rehabilitation care is the principal clinical intent (optional)

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.

Code 3.0 Palliative care

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:

CODE 3.1 Palliative care delivered in a designated unit (optional)

A designated palliative care unit 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.

CODE 3.2 Palliative care according to a designated program (optional)

In a designated palliative care program, 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.

CODE 3.3 Palliative care is the principal clinical intent (optional)

Palliative care as principal clinical intent 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.

CODE 4.0 Geriatric evaluation and management

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.

CODE 5.0 Psychogeriatric care

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 psychogeriatic care unit;
- in a designated psychogeriatic care program; or
- under the principal clinical management of a psychogeriatic physician or,
- in the opinion of the treating doctor, when the principal clinical intent of care is psychogeriatic care.

CODE 6.0 Maintenance care

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.

CODE 7.0 Newborn care

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
- 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.

CODE 8.0 Other admitted patient care

Other admitted patient care is care where the principal clinical intent does meet the criteria for any of the above.

Other care can be one of the following:

CODE 9.0 Organ procurement - posthumous (Other care)

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.

CODE 10.0 Hospital boarder (Other care)

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 of less cannot be boarders. They are admitted patients with each day of stay deemed to be either qualified or unqualified.

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.

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Care type, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (33.1 KB)

Is used in the formation of Episode of care—number of psychiatric care days, total N[NNNN] Health, Standard 01/03/2005

Implementation in Data Set Specifications: Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Admitted patient palliative care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient palliative care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient palliative care NMDS 2007-08 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient palliative care NMDS 2008-09 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient palliative care NMDS 2009-10 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient palliative care NMDS 2010-11 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Carer participation arrangements—carer consultants employed

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—carer participation arrangements status (carer consultants employed), code N
METeOR identifier:	288833
Registration status:	Health, Standard 08/12/2004
Definition:	Whether a specialised mental health service organisation has carer consultants employed on a paid basis to represent the interests of carers and advocate for their needs, to promote the participation of mental health carers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—carer participation arrangements status (carer consultants employed)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Supplementary values:

9	Not stated

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—carer participation arrangements status (formal complaints mechanism), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (carer satisfaction surveys), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (formal participation policy), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (regular discussion groups), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Carer participation arrangements—carer satisfaction surveys

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—carer participation arrangements status (carer satisfaction surveys), code N
METeOR identifier:	290367
Registration status:	Health, Standard 08/12/2004
Definition:	Whether a specialised mental health service organisation periodically conducts carer satisfaction surveys, to promote the participation of mental health carers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—carer participation arrangements status (carer satisfaction surveys)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—carer participation arrangements status (formal complaints mechanism), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (formal participation policy), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (regular discussion groups), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (carer consultants employed), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Carer participation arrangements—formal complaints mechanism

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—carer participation arrangements status (formal complaints mechanism), code N
METeOR identifier:	290370
Registration status:	Health, Standard 08/12/2004
Definition:	Whether a specialised mental health service organisation has a formal internal complaints mechanism in which complaints made by carers are regularly reviewed by a committee that includes carers, to promote the participation of mental health carers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—carer participation arrangements status (formal complaints mechanism)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Relational attributes

Related metadata references:	See also Specialised mental health service organisation—carer participation arrangements status (carer satisfaction surveys), code N Health, Standard 08/12/2004
	See also Specialised mental health service organisation—carer participation arrangements status (formal participation policy), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (regular discussion groups), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (carer consultants employed), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Carer participation arrangements—formal participation policy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—carer participation arrangements status (formal participation policy), code N
METeOR identifier:	290365
Registration status:	Health, Standard 08/12/2004
Definition:	Whether a specialised mental health service organisation has developed a formal and documented policy on participation by carers, to promote the participation of mental health carers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—carer participation arrangements status (formal participation policy)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Supplementary values:

9	Not stated

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—carer participation arrangements status (carer consultants employed), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (regular discussion groups), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (carer satisfaction surveys), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (formal complaints mechanism), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Carer participation arrangements—regular discussion groups

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—carer participation arrangements status (regular discussion groups), code N
METeOR identifier:	290359
Registration status:	Health, Standard 08/12/2004
Definition:	Whether the service holds regular discussion groups to seek the views of carers about the service, to promote the participation of mental health carers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—carer participation arrangements status (regular discussion groups)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—carer participation arrangements status (formal complaints mechanism), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (carer satisfaction surveys), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (formal participation policy), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—carer participation arrangements status (carer consultants employed), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Cataract—history

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—cataract status, code N
METeOR identifier:	270252
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the individual has a cataract present in either or both eyes or has had a cataract previously removed from either or both eyes, as represented by a code.
Data Element Concept:	Person—cataract status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Cataract currently present or has been previously removed from the right eye
2	Cataract currently present or has been previously removed from the left eye
3	Cataract currently present or has been previously removed from both eyes
4	No cataract present or has not been previously removed from either eye

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Collection methods:	Examination of the lens of the eye through a dilated pupil (visible through the pupil by the use of an ophthalmoscope) by an ophthalmologist or optometrist, as a part of the ophthalmological assessment. Ask the individual if he/she has a cataract in either or both eyes or has had a cataract removed from either or both eyes previously. Alternatively obtain information from an ophthalmologist or optometrist or from appropriate documentation.
Comments:	Cataract is a clouding of the lens of the eye or its capsule sufficient to reduce vision. The formation of cataract occurs more rapidly in patients with a history of ocular trauma, uveitis, or

diabetes mellitus. Cataract is an associated diabetic eye problem that could lead to blindness.

Regular eye checkups are important for patients suffering from diabetes mellitus. This helps to early detect abnormalities and to avoid or postpone vision-threatening complications. A comprehensive ophthalmological examination includes:

- check visual acuity with Snellen chart -correct with pinhole if indicated
- examine for cataract
- examine fundi with pupils dilated.

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:	Supersedes Cataract - history, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.4 KB)
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Superseded 21/09/2005 Diabetes (clinical) DSS Health, Standard 21/09/2005

Category reassignment date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective care waiting list episode—category reassignment date, DDMMYYYY
METeOR identifier:	270010
Registration status:	Health, Standard 01/03/2005
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.
Data Element Concept:	Elective care waiting list episode—category reassignment date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	The date needs to be recorded each time a patient's urgency classification or listing status changes.
Comments:	This date is necessary for the calculation of the waiting time at admission and the waiting time at a census date.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Category reassignment date, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.2 KB) Is used in the formation of Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] Health, Standard 01/03/2005 Is used in the formation of Elective surgery waiting list episode—waiting time (at a census date), total days N[NNN] Health, Standard 01/03/2005

Census date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Hospital census (of elective surgery waitlist patients)—census date, DDMMYYYY
METeOR identifier:	270153
Registration status:	Health, Standard 01/03/2005
Definition:	Date on which the hospital takes a point in time (census) count of and characterisation of patients on the waiting list.
Data Element Concept:	Hospital census (of elective surgery waitlist patients)—census date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	This date is recorded when a census is done of the patients on a waiting list.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Census date, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.4 KB) Is used in the formation of Elective surgery waiting list episode—waiting time (at a census date), total days N[NNN] Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Elective surgery waiting times (census data) NMDS Health, Superseded 07/12/2005 *Implementation start date:* 30/09/2002 *Implementation end date:* 30/06/2006 Elective surgery waiting times (census data) NMDS 2006-2009 Health, Superseded 03/12/2008 *Implementation start date:* 30/09/2006 *Implementation end date:* 31/03/2009 Elective surgery waiting times (census data) NMDS 2009- Health, Standard 03/12/2008 *Implementation start date:* 30/06/2009

Centrelink customer reference number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—government funding identifier, Centrelink customer reference number {N(9)A}
Synonymous names:	CRN; Centrelink reference number
METeOR identifier:	270098
Registration status:	Health, Standard 01/03/2005 Community services, Recorded 27/03/2007
Definition:	A personal identifier assigned by Centrelink for the purposes of identifying people (and organisations) eligible for specific services, including some public health care services, such as oral health services.
Data Element Concept:	Person—government funding identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	{N(9)A}
Maximum character length:	10

Data element attributes

Collection and usage attributes

Guide for use:	The CRN should only be collected from persons eligible to receive health services that are to be funded by Centrelink. The number may be reported to a Centrelink agency to reconcile payment for the service provided. The data should not be used by private sector organisations for any purpose unless specifically authorised by law. For example, data linkage should not be carried out unless specifically authorised by law.
Collection methods:	The Centrelink Customer Reference Number (CRN) is provided on 'Health Care Cards' and 'Pensioner Concession Cards'.
Comments:	When a person accesses health services on the basis of being a Centrelink customer, collection of the CRN is usually necessary. This data should not be collected and recorded if it is not needed to support the provision of such health services.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS5017 Health Care Client Identification

Relational attributes

Related metadata references:	Supersedes Centrelink customer reference number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (14.5 KB)
Implementation in Data Set Specifications:	Health care client identification Health, Superseded 04/05/2005
	Health care client identification DSS Health, Superseded 03/12/2008
	Health care client identification DSS Health, Standard 03/12/2008

Cerebral stroke due to vascular disease (history)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—cerebral stroke due to vascular disease (history), code N
METeOR identifier:	270355
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the individual has had a cerebral stroke due to vascular disease, as represented by a code.
Data Element Concept:	Person—cerebral stroke due to vascular disease

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Cerebral stroke - occurred in the last 12 months
2	Cerebral stroke - occurred prior to the last 12 months
3	Cerebral stroke - occurred both in and prior to the last 12 months
4	No history of cerebral stroke due to vascular disease

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Collection methods:	Obtain this information from appropriate documentation or from the patient.

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references:	Supersedes Cerebral stroke due to vascular disease - history, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.3 KB)
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Superseded 21/09/2005 Diabetes (clinical) DSS Health, Standard 21/09/2005

Change to body structure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—nature of impairment of body structure, code (ICF 2001) N
METeOR identifier:	320171
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The qualitative or quantitative change of a person's impairment in a specified body structure, as represented by a code.
Data Element Concept:	Person—nature of impairment of body structure

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Functioning, Disability and Health 2001
Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
0	No change in structure
1	Total absence
2	Partial absence
3	Additional part
4	Aberrant dimensions
5	Discontinuity
6	Deviating position
7	Qualitative changes in structure

Supplementary values:

8	Not specified
9	Not applicable

Collection and usage attributes

Guide for use:

This metadata item contributes to the definition of the concept '**Disability**' and gives an indication of the experience of disability for a person.

Impairments of body structure are problems in body structure such as a loss or significant departure from population standards or averages.

CODE 0 No change in structure

Used when the structure of the body part is within the range of the population standard.

CODE 1 Total absence

Used when the body structure is not present. For example total absence of the structures of the lower leg following a thorough knee amputation.

CODE 2 Partial absence

Used when only part of a body structure is present. For example partial absence of the bones of the lower leg following below knee amputation.

CODE 3 Additional part

Used when a structure, not usually present in the population is present, for example a sixth lumbar vertebra or an sixth digit on one hand.

CODE 4 Aberrant dimensions

Used when the shape and size of a body structure is significantly different from the population standard. For example radial aplasia where the shape and size of the radial bone does not develop.

CODE 5 Discontinuity

Used when parts of a body structure are separated, for example cleft palate or fracture.

CODE 6 Deviating position

Used when the location of a structure is not according to population standard; for example, transposition of the great vessels, where the aorta arises from the right ventricle and the pulmonary vessels from the left ventricle.

CODE 7 Qualitative changes in structure

Used when the structure of a body part is altered from the population standard. This includes accumulation of fluid, changes in bone structure as a result of osteoporosis or Paget's disease.

CODE 8 Not specified

Used when there is a change to a body structure, but the nature of the change is not described.

CODE 9 Not applicable

Used when it is not appropriate to code the nature of the change to a body structure.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.
Origin:	WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW
Reference documents:	Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide

(AIHW 2003), at the following websites:

- WHO ICF website
  http://www.who.int/classifications/icf/en/
- Australian Collaborating Centre ICF website
  http://www.aihw.gov.au/disability/icf/index.cfm

Data element attributes

Collection and usage attributes

Guide for use:

This data element is used in conjunction with specified body structures, for example 'partial absence of structures related to movement'. This data element may also be used in conjunction with Person—extent of impairment of body structure, code (ICF 2001) N and Person—location of impairment of body structure, code (ICF 2001) N.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references:

See also Person—location of impairment of body structure, code (ICF 2001) N Health, Standard 29/11/2006, Community services, Standard 16/10/2006

See also Person—extent of impairment of body structure, code (ICF 2001) N Health, Standard 29/11/2006, Community services, Standard 16/10/2006

Implementation in Data Set Specifications:

Body structures cluster Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Chest pain pattern category

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—chest pain pattern, code N
METeOR identifier:	356738
Registration status:	Health, Standard 01/10/2008
Definition:	The person's chest pain pattern, as represented by a code.
Data Element Concept:	Person—chest pain pattern

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Atypical chest pain
2	Stable chest pain pattern
3	Unstable chest pain pattern: rest &/or prolonged
4	Unstable chest pain pattern: new & severe
5	Unstable chest pain pattern: accelerated & severe
Supplementary values: 9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Chest pain or discomfort of myocardial ischaemic origin is usually described as pain, discomfort or pressure in the chest or the upper body (neck and throat, jaw, shoulders, back, either or both arms, wrists and hands) or other equivalent discomfort suggestive of cardiac ischaemia. Ask the person when the symptoms first occurred or obtain this information from appropriate documentation.

CODE 1 Atypical chest pain

Use this code for pain, pressure, or discomfort in the chest, or upper body not clearly exertional or not otherwise consistent with pain or discomfort of myocardial ischaemic origin.

CODE 2 Stable chest pain pattern

Use this code for chest pain without a change in frequency or pattern for the 6 weeks before this presentation or procedure. Chest pain is controlled by rest and/or sublingual/oral/transcutaneous medications.

CODE 3 Unstable chest pain pattern: rest and/or prolonged

Use this code for chest pain that occurred at rest and was prolonged, usually lasting for at least 10 minutes

CODE 4 Unstable chest pain pattern: new and severe

Use this code for new-onset chest pain that could be described as at least Canadian Cardiovascular Society (CCS) classification 3 severity.

CODE 5 Unstable chest pain pattern: accelerated and severe

Use this code for recent acceleration of chest pain pattern that could be described by an increase in severity of at least 1 CCS class to at least CCS class 3.

Data element attributes

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Relational attributes

Related metadata references: Supersedes Person—chest pain pattern, code N Health, Superseded 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Cholesterol—HDL (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—high-density lipoprotein cholesterol level (measured), total millimoles per litre [N].NN
METeOR identifier:	270401
Registration status:	Health, Standard 01/03/2005
Definition:	A person's high-density lipoprotein cholesterol (HDL-C), measured in mmol/L.
Data Element Concept:	Person—high-density lipoprotein cholesterol level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	[N].NN
Maximum character length:	3

Supplementary values:

Value	Meaning
9.99	Not measured/inadequately described

Unit of measure: Millimole per litre (mmol/L)

Data element attributes

Collection and usage attributes

Guide for use:

When reporting, record whether or not the measurement of High-density Lipoprotein Cholesterol (HDL-C) was performed in a fasting specimen.

In settings where the monitoring of a person's health is ongoing and where a measure can change over time (such as general practice), the date of assessment should be recorded.

Collection methods:

When reporting, record absolute result of the most recent HDL-Cholesterol measurement in the last 12 months to the nearest 0.01 mmol/L.

Measurement of lipid levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authorities.

- To be collected as a single venous blood sample, preferably following a 12-hour fast where only water and medications have been consumed.
- Prolonged tourniquet use can artefactually increase levels by up to 20%.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

National Diabetes Data Working Group

Origin: National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand, Lipid Management Guidelines - 2001, MJA 2001; 175: S57-S88.

Relational attributes

Related metadata references: Supersedes Cholesterol-HDL - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Is used in the formation of Person—low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N Health, Standard 01/10/2008

Is used in the formation of Person—low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N Health, Superseded 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Cholesterol—LDL (calculated)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N
METeOR identifier:	359262
Registration status:	Health, Standard 01/10/2008
Definition:	A person's calculated low-density lipoprotein cholesterol (LDL-C) in millimoles per litre.
Data Element Concept:	Person—low-density lipoprotein cholesterol level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N].N
Maximum character length:	3

Supplementary values:

Value	Meaning
99.9	Not stated/inadequately described

Unit of measure: Millimole per litre (mmol/L)

Data element attributes

Collection and usage attributes

Guide for use:

Formula:

LDL-C = (plasma total cholesterol) - (high density lipoprotein cholesterol) - (fasting plasma triglyceride divided by 2.2).

Collection methods:

The LDL-C is usually calculated from the Friedwald Equation (Friedwald et al. 1972), which depends on knowing the blood levels of the total cholesterol and HDL-C and the fasting level of the triglyceride.

Note that the Friedwald equation becomes unreliable when the plasma triglyceride exceeds 4.5 mmol/L.

Note also that while cholesterol levels are reliable for the first 24 hours after the onset of acute coronary syndromes, they may be unreliable for the subsequent 8 weeks after an event.

- Measurement of lipid levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authorities.
- To be collected as a single venous blood sample, preferably following a 12-hour fast where only water and medications have been consumed.

Comments:

High blood cholesterol is a key factor in heart, stroke and vascular disease, especially coronary heart disease (CHD).

Poor nutrition can be a contributing factor to heart, stroke and vascular disease as a population's level of saturated fat intake is the prime determinant of its level of blood cholesterol.

The majority of the cholesterol in plasma is transported as a component of LDL-C. Recent trials support a target LDL-C of <2.0 mmol/L for high risk patients with existing coronary heart disease.

Source and reference attributes

Submitting organisation:

Cardiovascular Data Working Group

Origin:

National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand, Lipid Management Guidelines - 2001, MJA 2001; 175: S57-S88.

National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand, Position Statement on Lipid Management - 2005, Heart, Lung and Circulation 2005; 14: 275-291.

Relational attributes

Related metadata references:

Supersedes Person—low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N Health, Superseded 01/10/2008

Is formed using Person—cholesterol level (measured), total millimoles per litre N[N].N Health, Superseded 01/10/2008

Is formed using Person—high-density lipoprotein cholesterol level (measured), total millimoles per litre [N].NN Health, Standard 01/03/2005

Is formed using Person—triglyceride level (measured), total millimoles per litre N[N].N Health, Superseded 01/10/2008

Is formed using Health service event—fasting indicator, code N Health, Standard 21/09/2005

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Cholesterol—total (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—cholesterol level (measured), total millimoles per litre N[N].N
METeOR identifier:	359245
Registration status:	Health, Standard 01/10/2008
Definition:	A person's total cholesterol (TC), measured in millimoles per litre.
Data Element Concept:	Person—cholesterol level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N].N
Maximum character length:	3

Supplementary values:

Value	Meaning
99.9	Not stated/inadequately described.

Unit of measure: Millimole per litre (mmol/L)

Data element attributes

Collection and usage attributes

Guide for use:

Measurement in mmol/L to 1 decimal place.

Record the absolute result of the total cholesterol measurement. When reporting, record whether or not the measurement of Cholesterol-total - measured was performed in a fasting specimen.

Collection methods:

When reporting, record absolute result of the most recent Cholesterol-total - measured in the last 12 months to the nearest 0.1 mmol/L.

Measurement of lipid levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authorities.

- To be collected as a single venous blood sample, preferably following a 12-hour fast where only water and medications have been consumed.
- Prolonged tourniquet use can artefactually increase levels by up to 20%.

Comments:

In settings where the monitoring of a person's health is ongoing and where a measure can change over time (such as general practice), the Service contact—service contact date, DDMMYYYY should be recorded.

High blood cholesterol is a key factor in heart, stroke and vascular disease, especially coronary heart disease.

Poor nutrition can be a contributing factor to heart, stroke and vascular disease as a population's level of saturated fat intake is the prime determinant of its level of blood cholesterol.

Large clinical trials have shown that people at highest risk of cardiovascular events (e.g. pre-existing ischaemic heart disease) will derive the greatest benefit from lipid lowering drugs. Recent trials have suggested that there should be no cholesterol level threshold for the initiation of treatment in tis group of patients. In October 2006, the PBS criteria for lipid-lowering drugs was expanded to include all patients identified as high-risk (based on PBS criteria) regardless of their cholesterol level.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Origin: National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand, Lipid Management Guidelines - 2001, MJA 2001; 175: S57-S88

National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand, Position Statement on Lipid Management - 2005, Heart Lung and Circulation 2005; 14: 275-291.

National Health Priority Areas Report: Cardiovascular Health 1998. AIHW Cat. No. PHE 9. HEALTH and AIHW, Canberra.

The Royal College of Pathologists of Australasia web based Manual of Use and Interpretation of Pathology Tests. Version 4.0.

Relational attributes

Related metadata references: Supersedes Person—cholesterol level (measured), total millimoles per litre N[N].N Health, Superseded 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Classification of health labour force job

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health professional—occupation, code ANN
METeOR identifier:	270140
Registration status:	Health, Standard 01/03/2005
Definition:	The position or job classification of a health professional, as represented by a code.
Data Element Concept:	Health professional—occupation

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	ANN
Maximum character length:	3

Permissible values:

Value	Meaning
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: Resident medical officer 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)
C12	Nursing - Associate professor/professor in nursing (tertiary institution)
C98	Nursing - Other (specify)
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
Supplementary values:	C99	Nursing - Unknown/inadequately described/not stated

Data element attributes

Collection and usage attributes

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.

Source and reference attributes

Submitting organisation: National Health Labour Force Data Working Group

Relational attributes

Related metadata references: Supersedes Classification of health labour force job, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (24.7 KB)

Implementation in Data Set Specifications: Health labour force NMDS Health, Standard 01/03/2005

Implementation start date: 01/07/2005

Client type (alcohol and other drug treatment services)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—client type, code N
METeOR identifier:	270083
Registration status:	Health, Standard 01/03/2005
Definition:	The status of a person in terms of whether the treatment episode concerns their own alcohol and/or other drug use or that of another person, as represented by a code.
Data Element Concept:	Episode of treatment for alcohol and other drugs—client type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Own alcohol or other drug use
2	Other's alcohol or other drug use

Collection and usage attributes

Guide for use:

CODE 1 Own alcohol or other drug use

Use this code for a client who receives treatment or assistance concerning their own alcohol and/or other drug use.

Use this code where a client is receiving treatment or assistance for both their own alcohol and/or other drug use and the alcohol and/or other drug use of another person.

CODE 2 Other's alcohol or other drug use

Use this code for a client who receives support and/or assistance in relation to the alcohol and/or other drug use of another person.

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

Data element attributes

Collection and usage attributes

Guide for use:

Where Code 2 Other's alcohol or other drug use is reported, do not collect the following data elements:

Episode of treatment for alcohol and other drugs—drug of concern (principal), code (ASCDC 2000 extended) NNNN;

Episode of treatment for alcohol and other drugs—drug of concern (other), code (ASCDC 2000 extended) NNNN;

Client—injecting drug use status, code N; and

Client—method of drug use (principal drug of concern), code N.

Comments: Required to differentiate between clients according to whether the treatment episode concerns their own alcohol and/or other drug use or that of another person to provide a basis for description of the people accessing alcohol and other drug treatment services.

Source and reference attributes

Submitting organisation: Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references: Supersedes Client type - alcohol and other drug treatment services, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.5 KB)

Implementation in Data Set Specifications: Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Alcohol and other drug treatment services NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Clinical evidence of acute coronary syndrome related medical history

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—clinical evidence status (acute coronary syndrome related medical history), yes/no code N
METeOR identifier:	356777
Registration status:	Health, Standard 01/10/2008
Definition:	An indicator of whether there is objective evidence for a person's history of an acute coronary syndrome related medical condition, as represented by a code.
Data Element Concept:	Person—clinical evidence status (acute coronary syndrome related medical history)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 9 Not stated/inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes

Use this code where there is objective evidence to support a history of an acute coronary syndrome related medical condition.

CODE 2 No

Use this code where the history is not supported by objective evidence.

Objective evidence for acute coronary syndrome related medical conditions are classified as:

Chronic lung disease:

Diagnosis supported by current use of chronic lung disease pharmacological therapy (e.g. inhalers, theophylline,

aminophylline, or steroids), or a forced expiratory volume in 1 second (FEV1) less than 80% predicted FEV1/forced vital capacity (FVC) less than 0.7 (post bronchodilator). Respiratory failure partial pressure of oxygen (PaO2) less than 60 mmHg (8kPa), or partial pressure of carbon dioxide (PaCO2) greater than 50 mmHg (6.7 kPa).

Heart failure:

Current symptoms of heart failure (typically shortness of breath or fatigue), either at rest or during exercise and/or signs of pulmonary or peripheral congestion and objective evidence of cardiac dysfunction at rest. The diagnosis is derived from and substantiated by clinical documentation from testing according to current practices.

Stroke:

Diagnosis for ischaemic: non-haemorrhagic cerebral infarction or haemorrhagic: intracerebral haemorrhage supported by cerebral imaging (CT or MRI).

Peripheral arterial disease:

- Peripheral artery disease: diagnosis is derived from and substantiated by clinical documentation for a person with a history of either chronic or acute occlusion or narrowing of the arterial lumen in the aorta or extremities.
- Aortic aneurysm: diagnosis of aneurysmal dilatation of the aorta (thoracic and or abdominal) supported and substantiated by appropriate documentation of objective testing.
- Renal artery stenosis: diagnosis of functional stenosis of one or both renal arteries is present and is supported and substantiated by appropriate documentation of objective testing.

Sleep apnoea:

Diagnosis derived from and substantiated by clinical documentation of sleep apnoea syndrome (SAS). SAS has been diagnosed from the results of a sleep study.

Other vascular conditions:

- Atrial fibrillation: diagnosis supported by electrocardiogram findings.
- Other cardiac arrhythmias and conductive disorders: diagnosis supported by electrocardiogram findings.
- Left ventricular hypertrophy: diagnosis supported by echocardiograph evidence.

Collection methods:

For each of the following medical conditions the clinical evidence status must also be recorded:

- Chronic lung disease
- Heart failure
- Stroke
- Peripheral arterial disease

- Sleep apnoea syndrome
- Other vascular conditions

Comments:

Heart failure:

Chronic heart failure is a complex clinical syndrome with typical symptoms (e.g. shortness of breath, fatigue) that can occur at rest or on effort, and is characterised by objective evidence of an underlying structural abnormality of cardiac dysfunction that impairs the ability of the ventricle to fill with or eject blood (particularly during physical activity).

The most widely available investigation for documenting left ventricular dysfunction is the transthoracic echocardiogram (TTE).

Other modalities include:

- transoesophageal echocardiography (TOE)
- gated radionuclide angiocardiography
- angiographic left ventriculography

In the absence of any adjunctive laboratory tests, evidence of supportive clinical signs of ventricular dysfunction. These include:

- cardiac auscultation (S3, cardiac murmurs),
- cardiomegaly,
- elevated jugular venous pressure (JVP),
- chest X-ray evidence of pulmonary congestion

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Reference documents: The Thoracic Society of Australia & New Zealand and the Australian Lung Foundation, Chronic Obstructive Pulmonary Disease (COPD) Australian & New Zealand Management Guidelines and the COPD Handbook. Version 1, November 2002.

National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand (Chronic Heart Failure Guidelines Expert Writing Panel). Guidelines for the prevention, detection and management of chronic heart failure in Australia, 2006.

Relational attributes

Related metadata references:

Supersedes Person—clinical evidence status (chronic lung disease), code N Health, Superseded 01/10/2008

Supersedes Person—clinical evidence status (heart failure), code N Health, Superseded 01/10/2008

Supersedes Person—clinical evidence status (peripheral arterial disease), code N Health, Superseded 01/10/2008

Supersedes Person—clinical evidence status (sleep apnoea syndrome), code N Health, Superseded 01/10/2008

Supersedes Person—clinical evidence status (stroke), code N Health, Superseded 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Clinical procedure timing (status)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—clinical procedure timing, code N
METeOR identifier:	356827
Registration status:	Health, Standard 01/10/2008
Definition:	The timing of the provision of a clinical procedure, as represented by a code.
Data Element Concept:	Person—clinical procedure timing

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Procedure performed prior to this hospital presentation
2	Procedure performed during this hospital presentation

Data element attributes

Collection and usage attributes

Guide for use:	Record only for those procedure codes that apply.
Collection methods:	This data element should be recorded for each type of procedure performed that is pertinent to the treatment of acute coronary syndrome.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group

Relational attributes

Related metadata references:	See also Person—acute coronary syndrome procedure type, code NN Health, Standard 01/10/2008 Supersedes Person—clinical procedure timing, code N Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Clinical urgency

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—clinical urgency, code N
METeOR identifier:	270008
Registration status:	Health, Standard 01/03/2005
Definition:	A clinical assessment of the urgency with which a patient requires elective hospital care, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode—clinical urgency

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
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

Data element attributes

Collection and usage attributes

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.
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 (metadata item Elective care waiting list episode—category reassignment date, DDMMYYYY).

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Clinical urgency, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.4 KB)

See also Elective surgery waiting list episode—overdue patient status, code N Health, Standard 01/03/2005

Implementation in Data Set Specifications: Elective surgery waiting times (census data) NMDS Health, Superseded 07/12/2005

Implementation start date: 30/09/2002

Implementation end date: 30/06/2006

Elective surgery waiting times (census data) NMDS 2006-2009 Health, Superseded 03/12/2008

Implementation start date: 30/09/2006

Implementation end date: 31/03/2009

Elective surgery waiting times (census data) NMDS 2009- Health, Standard 03/12/2008

Implementation start date: 30/06/2009

Elective surgery waiting times (removals data) NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2002

Implementation end date: 30/06/2006

Elective surgery waiting times (removals data) NMDS 2006-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2006

Implementation end date: 30/06/2009

Elective surgery waiting times (removals data) NMDS 2009- Health, Standard 03/12/2008

Implementation start date: 01/07/2009

Clopidogrel therapy status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—clopidogrel therapy status, code NN
METeOR identifier:	284873
Registration status:	Health, Standard 04/06/2004
Definition:	The person's clopidogrel therapy status, as represented by a code.
Data Element Concept:	Person—clopidogrel therapy status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
10	Given
21	Not given - therapy not indicated
22	Not given - patient refusal
23	Not given - true allergy to clopidogrel
24	Not given - active bleeding
25	Not given - bleeding risk
26	Not given - thrombocytopenia
27	Not given - severe hepatic dysfunction
29	Not given - other

Supplementary values:

Value	Meaning
90	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODES 21 - 29 Not given If recording 'Not given', record the principal reason if more than one code applies.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Clopidogrel therapy status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008
	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Co-location status of mental health service

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—co-location with acute care hospital, code N
METeOR identifier:	286995
Registration status:	Health, Standard 08/12/2004
Definition:	Whether a mental health service is co-located with an acute care hospital, as represented by a code.
Data Element Concept:	Specialised mental health service—co-location with acute care hospital

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Co-located
2	Not co-located

Collection and usage attributes

Guide for use:

CODE 1 Co-located

Co-located health services are those that are established physically and organisationally as part of an acute care hospital service. There are two forms of co-location:

- a health service that is built and managed as a ward or unit within an acute care hospital; or
- the health service operates in a separate building but is located on, or immediately adjoining, the acute care hospital campus.

In the second option, units and wards within a psychiatric hospital may be classified as co-located when all the following criteria apply:

- a single organisational or management structure covers the acute care hospital and the psychiatric hospital;
- a single employer covers the staff of the acute care hospital and the psychiatric hospital;
- the location of the acute care hospital and psychiatric hospital can be regarded as part of a single overall hospital campus; and
- the patients of the psychiatric hospital are regarded as patients of the single integrated health service.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Collection methods: To be reported for mental health services that primarily provide overnight admitted patient care. Excludes residential mental health services and ambulatory mental health services.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Compensable status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—compensable status, code N
METeOR identifier:	270100
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a patient is a **compensable patient**, as represented by a code.
Data Element Concept:	Patient—compensable status

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Compensable
	2	Non-compensable
Supplementary values:	9	Not stated/not known

Data element attributes

Collection and usage attributes

Guide for use:	This definition of **compensable patient** excludes eligible beneficiaries (Department of Veterans' Affairs), Defence Force personnel and persons covered by the Motor Accident Compensation Scheme, Northern Territory.
Comments:	To assist in the analyses of utilisation and health care funding.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Compensable status, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.2 KB)
Implementation in Data Set Specifications:	Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Non-admitted patient emergency department care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Complication of labour and delivery

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—complication, code (ICD-10-AM 7th edn) ANN{.N[N]}
METeOR identifier:	391338
Registration status:	Health, Standard 22/12/2009
Definition:	Medical and obstetric complications (necessitating intervention) arising after the onset of labour and before the completed delivery of the baby and placenta, as represented by a code.
Data Element Concept:	Birth event—complication

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Collection and usage attributes

Guide for use:	Complications and conditions should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM.

Data element attributes

Collection and usage attributes

Guide for use:	There is no arbitrary limit on the number of conditions specified.
Comments:	Complications of labour and delivery may cause maternal morbidity and may affect the health status of the baby at birth.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Birth event—complication, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009

Complications of pregnancy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Pregnancy (current)—complication, code (ICD-10-AM 7th edn) ANN{.N[N]}
METeOR identifier:	405823
Registration status:	Health, Standard 22/12/2009
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, as represented by a code
Data Element Concept:	Pregnancy (current)—complication

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Collection and usage attributes

Guide for use:	Complications and conditions should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM.

Data element attributes

Collection and usage attributes

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.
Comments:	Complications often influence the course and outcome of pregnancy, possibly resulting in hospital admissions and/or adverse effects on the fetus and perinatal morbidity.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Pregnancy (current)—complication, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009

Condition onset flag

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—condition onset flag, code N
METeOR identifier:	354816
Registration status:	Health, Standard 05/02/2008
Definition:	A qualifier for each coded diagnosis to indicate the onset of the condition relative to the beginning of the episode of care, as represented by a code.
Data Element Concept:	Episode of admitted patient care—condition onset flag

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Condition with onset during the episode of admitted patient care
2	Condition not noted as arising during the episode of admitted patient care

Supplementary values:

9	Not reported

Collection and usage attributes

Guide for use:

1 Condition with onset during the episode of admitted patient care

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

Includes:

Conditions resulting from misadventure during medical or surgical care during the episode of admitted patient care.

Abnormal reactions to, or later complication of, surgical or medical care arising during the episode of admitted patient care.

Conditions arising during the episode of admitted patient care not related to surgical or medical care (for example, pneumonia).

2 Condition not noted as arising during the episode of admitted patient care

- a condition present on admission such as the presenting problem, a comorbidity, chronic disease or disease status.
- a previously existing condition not diagnosed until the episode of admitted patient care.

Includes:

In the case of neonates, the conditions present at birth.

A previously existing condition that is exacerbated during the episode of admitted patient care.

Conditions that are suspected at the time of admission and subsequently confirmed during the episode of admitted patient care.

Conditions that were not diagnosed at the time of admission but clearly did not develop after admission (for example malignant neoplasm).

Conditions where the onset relative to the beginning of the episode of admitted patient care is unclear or unknown.

9 Not reported

The condition onset flag could no be reported due to limitations of the data management system.

Data element attributes

Collection and usage attributes

Guide for use:

Assign the relevant condition onset flag to ICD-10-AM diagnosis codes assigned in the principal diagnosis and additional diagnosis fields for the National Hospital Morbidity Database collection.

The sequencing of diagnosis codes must comply with the Australian Coding Standards and therefore diagnosis codes should not be re-sequenced in an attempt to list diagnosis codes with the same condition onset flag together.

When it is difficult to decide if a condition was present at the beginning of the episode of care or if it arose during the episode, assign a value of 2 - Condition not noted as arising during this episode of care.

The principal diagnosis should always have a condition onset flag value of 2.

Explanatory notes:

The flag on external cause, place of occurrence and activity codes should match that of the corresponding injury or disease code.

The flag on morphology codes should match that on the corresponding neoplasm code

When a single diagnosis code describes a condition and that code contains more than one concept (e.g. diabetes with renal complications) and each concept within that code has a different condition onset flag, then assign a value of 2.

When a condition requires more than one diagnosis code to describe it, it is possible for each diagnosis code to have a different condition onset flag.

The flag on Z codes related to the outcome of delivery on the mother's record (Z37), should always be assigned a value of 2.

The flag on Z codes related to the outcome of delivery on the baby's record (Z38), should always be assigned a value of 2.

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

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

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

Source and reference attributes

Origin: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Episode of admitted patient care—diagnosis onset type, code N Health, Superseded 05/02/2008

Implementation in Data Set Specifications: Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Congenital malformations

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—congenital malformation, code (ICD-10-AM 7th edn) ANN{.N[N]}
METeOR identifier:	393436
Registration status:	Health, Standard 22/12/2009
Definition:	Structural abnormalities (including deformations) that are present at birth and diagnosed prior to **separation** from care, as represented by an ICD-10-AM code.
Context:	Admitted patient care
Data Element Concept:	Person—congenital malformation

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Source and reference attributes

Origin:	International Classification of Diseases - 10th Revision, Australian Modification National Centre for Classification in Health, Sydney.

Data element attributes

Collection and usage attributes

Guide for use:	Coding to the disease classification of ICD-10-AM is the preferred method of coding admitted patients.
Comments:	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.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Person—congenital malformation, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009

Congenital malformations—BPA code

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—congenital malformation, code (BPA 1979) ANN.N[N]
METeOR identifier:	270408
Registration status:	Health, Standard 01/03/2005
Definition:	Structural abnormalities (including deformations) that are present at birth and diagnosed prior to **separation** from care, as represented by a BPA code.
Context:	Perinatal statistics
Data Element Concept:	Person—congenital malformation

Value domain attributes

Representational attributes

Classification scheme:	British Paediatric Association Classification of Diseases 1979
Representation class:	Code
Data type:	String
Format:	ANN.N[N]
Maximum character length:	5

Data element attributes

Collection and usage attributes

Guide for use:	Coding to the disease classification of ICD-10-AM is the preferred method of coding admitted patients. For perinatal data collections, the use of British Paediatric Association (BPA) Classification of Diseases is preferred as this is more detailed.
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 BPA Classification of Diseases to code congenital malformations since the early 1980s.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee
Origin:	British Paediatric Association Classification of Diseases (1979)

Relational attributes

Related metadata references:	Supersedes Congenital malformations - BPA code, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Consumer committee representation arrangements

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—consumer committee representation arrangements, code N
METeOR identifier:	288855
Registration status:	Health, Standard 08/12/2004
Definition:	Extent to which a specialised mental health service organisation has formal committee mechanisms in place to promote the participation of mental health consumers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—consumer committee representation arrangements

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Formal position(s) for consumers exist on the organisation's management committee for the appointment of person(s) to represent the interests of consumers
2	Specific consumer advisory committee(s) exists to advise on all relevant mental health services managed by the organisation
3	Specific consumer advisory committee(s) exists to advise on some but not all relevant mental health services managed by the organisation
4	Consumers participate on a broadly based advisory committee which include a mixture of organisations and groups representing a wide range of interests
5	Consumers are not represented on any advisory committee but are encouraged to meet with senior representatives of the organisation as required
6	No specific arrangements exist for consumer participation in planning and evaluation of services

Collection and usage attributes

Guide for use: Select the option above that best describes the type of formal committee mechanisms within your organisation for ensuring participation by mental health consumers in the planning and evaluation of services.

Data element attributes

Collection and usage attributes

Guide for use: Select the option above that best describes the type of formal committee mechanisms with in your organisation for ensuring participation by mental health consumers in the planning and evaluation of services.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Consumer participation arrangements—consumer consultants employed

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—consumer participation arrangements (consumer consultants employed), code N
METeOR identifier:	288866
Registration status:	Health, Standard 08/12/2004
Definition:	Whether the service employs consumer consultants on a paid basis to represent the interests of consumers and advocate for their needs, in order to promote the participation of mental health consumers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—consumer participation arrangements (consumer consultants employed)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Supplementary values:

9	Don't know

Data element attributes

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—consumer participation arrangements (consumer satisfaction surveys), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (formal complaints mechanism), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (formal participation policy), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (regular discussion groups), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Consumer participation arrangements—consumer satisfaction surveys

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—consumer participation arrangements (consumer satisfaction surveys), code N
METeOR identifier:	290418
Registration status:	Health, Standard 08/12/2004
Definition:	Whether the service conducts consumer satisfaction surveys, in order to promote the participation of mental health consumers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—consumer participation arrangements (consumer satisfaction surveys)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Boolean	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Don't know

Data element attributes

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—consumer participation arrangements (consumer consultants employed), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (formal complaints mechanism), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (formal participation policy), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (regular discussion groups), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Consumer participation arrangements—formal complaints mechanism

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—consumer participation arrangements (formal complaints mechanism), code N
METeOR identifier:	290415
Registration status:	Health, Standard 08/12/2004
Definition:	Whether the service has developed a formal internal complaints mechanism in which complaints can be made by consumers and are regularly reviewed by a committee that includes consumers, in order to promote the participation of mental health consumers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—consumer participation arrangements (formal internal complaints mechanism)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Boolean	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Don't know

Data element attributes

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—consumer participation arrangements (regular discussion groups), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (formal participation policy), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (consumer satisfaction surveys), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (consumer consultants

employed), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Consumer participation arrangements—formal participation policy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—consumer participation arrangements (formal participation policy), code N
METeOR identifier:	290410
Registration status:	Health, Standard 08/12/2004
Definition:	Whether the service has developed a formal and documented policy on participation by consumers, in order to promote the participation of mental health consumers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—consumer participation arrangements (formal participation policy)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Boolean	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Don't know

Data element attributes

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—consumer participation arrangements (consumer consultants employed), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (consumer satisfaction surveys), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (formal complaints mechanism), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (regular discussion groups), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Consumer participation arrangements—regular discussion groups

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—consumer participation arrangements (regular discussion groups), code N
METeOR identifier:	290408
Registration status:	Health, Standard 08/12/2004
Data Element Concept:	Specialised mental health service organisation—consumer participation arrangements (regular discussion groups)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Supplementary values:

9	Don't know

Data element attributes

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—consumer participation arrangements (formal participation policy), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (formal complaints mechanism), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (consumer satisfaction surveys), code N Health, Standard 08/12/2004

See also Specialised mental health service organisation—consumer participation arrangements (consumer consultants employed), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Contract establishment identifier

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Contracted hospital care—organisation identifier, NNX[X]NNNNN
METeOR identifier:	270013
Registration status:	Health, Standard 01/03/2005
Definition:	The unique establishment identifier of the other hospital involved in the contracted care.
Data Element Concept:	Contracted hospital care—organisation identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	NNX[X]NNNNN
Maximum character length:	9

Data element attributes

Collection and usage attributes

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.

Relational attributes

Related metadata references:	Supersedes Contract establishment identifier, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)

Contract procedure flag

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care (procedure)—contracted procedure flag, code N
METeOR identifier:	270473
Registration status:	Health, Standard 01/03/2005
Definition:	Designation that a procedure was not performed in this hospital but was performed by another hospital as a contracted service, as represented by a code.
Data Element Concept:	Episode of care (procedure)—contracted procedure flag

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	[N]
Maximum character length:	1

Permissible values:

Value	Meaning
1	Contracted admitted procedure
2	Contracted non-admitted procedure

Data element attributes

Collection and usage attributes

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.

Relational attributes

Related metadata references:

Supersedes Contract procedure flag, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.3 KB)

Contract role

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Hospital—contract role, code A
METeOR identifier:	270114
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the hospital is the purchaser of hospital care or the provider of an admitted or non-admitted service, as represented by a code.
Data Element Concept:	Hospital—contract role

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A
Maximum character length:	1

Permissible values:

Value	Meaning
A	Hospital A
B	Hospital B

Collection and usage attributes

Guide for use:

CODE A Hospital A

Hospital A is the contracting hospital (purchaser).

CODE B Hospital B

Hospital B is the contracted hospital (provider).

Data element attributes

Relational attributes

Related metadata references:

Supersedes Contract role, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)

Is used in the formation of Episode of admitted patient care—inter-hospital contracted patient status, code N Health, Standard 01/03/2005

Contract type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Hospital—contract type, code N
METeOR identifier:	270475
Registration status:	Health, Standard 01/03/2005
Definition:	The type of contract arrangement between contractor and the contracted hospital, as represented by a code.
Data Element Concept:	Hospital—contract type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Contract type B
2	Contract type ABA
3	Contract type AB
4	Contract type (A)B
5	Contract type BA

Collection and usage attributes

Guide for use:

The contracting hospital (purchaser) is termed Hospital A. The contracted hospital (provider) is termed Hospital B.

CODE 1 Contract Type B

A health authority / other external purchaser contracts hospital B for admitted service which is funded outside the standard funding arrangements.

CODE 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.

For 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.

CODE 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.

For 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.

CODE 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. For example, a patient is admitted for endoscopy at Hospital B under contract to Hospital A.

CODE 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. For example, a patient is admitted to Hospital B for a gastric resection procedure under contract to Hospital A and Hospital A provides after care.

Data element attributes

Relational attributes

Related metadata references:

Supersedes Contract type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)

Is used in the formation of Episode of admitted patient care—inter-hospital contracted patient status, code N Health, Standard 01/03/2005

Contracted care commencement date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Contracted hospital care—contracted care commencement date, DDMMYYYY
METeOR identifier:	270105
Registration status:	Health, Standard 01/03/2005
Definition:	The date the period of contracted care commenced.
Data Element Concept:	Contracted hospital care—contracted care commencement date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	This metadata 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.

Relational attributes

Related metadata references:	Supersedes Contracted care commencement date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.7 KB)

Contracted care completion date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Contracted hospital care—contracted care completed date, DDMMYYYY
METeOR identifier:	270106
Registration status:	Health, Standard 01/03/2005
Definition:	The date the period of contracted care is completed.
Data Element Concept:	Contracted hospital care—contracted care completed date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item is to be used by the contracting hospital to record the date of completion of the contracted hospital care and will be the separation date for the contracted hospital.

Relational attributes

Related metadata references:	Supersedes Contracted care completion date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.7 KB)

Coordinator of volunteers indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—coordinator of volunteers indicator, yes/no code N
METeOR identifier:	352862
Registration status:	Health, Standard 05/12/2007
Definition:	An indicator of whether a service provider organisation has at least one designated person to coordinate their volunteer labour force, as represented by a code.
Data Element Concept:	Service provider organisation—coordinator of volunteers indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

A coordinator of volunteers may be employed part-time or full-time and may be engaged on a paid or unpaid basis.

The duties of a volunteer coordinator may include:

- managing the workloads of volunteer staff;
- liaising with clinical staff regarding clients' needs;
- assessing human resource needs of the organisation;
- recruiting volunteers;
- developing orientation kits and programs;
- developing volunteer policies;
- arranging training and development opportunities; and
- maintaining volunteer records.

CODE 1 Yes

The organisation has a designated coordinator of volunteers.

CODE 2 No

The organisation does not have a designated coordinator of volunteers.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications: Palliative care performance indicators DSS Health, Standard 05/12/2007

Coronary artery bypass graft location

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—coronary artery bypass graft location, code N
METeOR identifier:	347161
Registration status:	Health, Standard 01/10/2008
Definition:	The location of the artery where a coronary artery bypass graft has been performed, as represented by a code.
Data Element Concept:	Person—coronary artery bypass graft location

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Left anterior descending artery (LAD)
2	Diagonal artery
3	Left circumflex artery (LCx)
4	Inferior surface artery
5	Posterior descending artery
6	Right coronary artery
8	Other artery

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

A bypass may be performed on more than one artery. In these cases more than one code may be recorded.

For each graft location the data elements Person-coronary artery stenosis location, code N; Person-maximum stenosis coronary artery, percentage N[NN] must also be recorded.

Relational attributes

Implementation in Data Set Specifications:

Coronary artery cluster Health, Standard 01/10/2008

Conditional obligation:
Record when a coronary artery bypass graft is performed.

Coronary artery disease—history of intervention or procedure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—coronary artery disease intervention (history), code N
METeOR identifier:	270227
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the individual has undergone a coronary artery by-pass grafting (CABG), angioplasty or stent, as represented by a code.
Data Element Concept:	Person—coronary artery disease intervention

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	CABG, angioplasty or stent - undertaken in last 12 months
2	CABG, angioplasty or stent - undertaken prior to the last 12 months
3	CABG, angioplasty or stent - both within and prior to the last 12 months
4	No CABG, angioplasty or stent undertaken

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Comments:

CABG is known as 'bypass surgery' when a piece of vein (taken from the leg) or of an artery (taken from the chest or wrist) is used to form a connection between the aorta and the coronary artery distal to the obstructive lesion, making a bypass around the blockage. Angioplasty is an **elective surgery** technique of blood vessels reconstruction.

Stenting is a non-surgical treatment used with balloon angioplasty or after, to treat coronary artery disease to widen a coronary artery. A stent is a small, expandable wire mesh tube that is inserted. The purpose of the stent is to help hold the newly treated artery open, reducing the risk of the artery re-closing (re-stenosis) over time.

Angioplasty with stenting typically leaves less than 10% of the original blockage in the artery (Heart Center Online).

These three procedures are commonly used to improve blood flow to the heart muscle when the heart's arteries are narrowed or blocked.

The sooner procedures are done, the greater the chances of saving heart muscle.

Data element attributes

Collection and usage attributes

Collection methods: Ask the individual if he/she has had a CABG, angioplasty or coronary stent. If so determine when it was undertaken within or prior to the last 12 months (or both).

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references: Supersedes Coronary artery disease - history of intervention or procedure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.3 KB)

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Coronary artery stenosis location

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—coronary artery stenosis location, code N
METeOR identifier:	361087
Registration status:	Health, Standard 01/10/2008
Definition:	The coronary artery in which stenosis is located, as represented by a code.
Data Element Concept:	Person—coronary artery stenosis location

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Left anterior descending artery (LAD)
2	Diagonal artery
3	Left circumflex artery (LCx)
4	Left main coronary artery
5	Inferior surface artery
6	Posterior descending artery
7	Right coronary artery

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	More than one code may be recorded. Record all codes that apply. For each coronary artery where stenosis is located the data element Person-maximum stenosis coronary artery, percentage N[NN] must also be recorded.
Collection methods:	This data is derived from visual reporting by the physician reporting the angiogram.

Relational attributes

Related metadata references:	See also Person—maximum stenosis coronary artery, percentage N[NN] Health, Standard 01/10/2008
Implementation in Data Set Specifications:	Coronary artery cluster Health, Standard 01/10/2008

Country of birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—country of birth, code (SACC 2008) NNNN
METeOR identifier:	370943
Registration status:	Health, Standard 01/10/2008 Community services, Standard 02/06/2008 Housing assistance, Standard 24/11/2008
Definition:	The country in which the person was born, as represented by a code.
Data Element Concept:	Person—country of birth

Value domain attributes

Representational attributes

Classification scheme:	Standard Australian Classification of Countries 2008
Representation class:	Code
Data type:	Number
Format:	NNNN
Maximum character length:	4

Collection and usage attributes

Guide for use:

The Standard Australian Classification of Countries 2008 (SACC) is a four-digit, three-level hierarchical structure specifying major group, minor group and country.

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.

Data element attributes

Collection and usage attributes

Collection methods:

Some data collections ask respondents to specify their country of birth. In others, a pre-determined set of countries is specified as part of the question, usually accompanied by an 'other (please specify)' category.

Recommended questions are:

In which country were you/was the person/was (name) born?

Australia

Other (please specify)

Alternatively, a list of countries may be used based on, for example common Census responses.

In which country were you/was the person/was (name) born?

Australia

England

New Zealand

Italy

Viet Nam

India

Scotland

Philippines

Greece

Germany

Other (please specify)

In either case coding of data should conform to the SACC.

Sometimes respondents are simply asked to specify whether they were born in either 'English speaking' or 'non-English speaking' countries but this question is of limited use and this method of collection is not recommended.

Comments:

This metadata item is consistent with that used in the ABS collection methods and is recommended for use whenever there is a requirement for comparison with ABS data (last viewed 2/6/2008).

Relational attributes

Related metadata references:

Supersedes Person—country of birth, code (SACC 1998) NNNN Health, Superseded 01/10/2008, Community services, Superseded 02/06/2008, Housing assistance, Superseded 24/11/2008

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Admitted patient mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Admitted patient palliative care NMDS 2009-10 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient palliative care NMDS 2010-11 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Alcohol and other drug treatment services NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Community mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Community mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Computer Assisted Telephone Interview demographic module DSS Health, Standard 03/12/2008

Health care client identification DSS Health, Standard 03/12/2008

Non-admitted patient emergency department care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Perinatal NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Registered chiropractic labour force DSS Health, Standard 10/12/2009

Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009

Registered medical professional labour force DSS Health, Standard 10/12/2009

Registered midwifery labour force DSS Health, Standard 10/12/2009

Registered nursing professional labour force DSS Health, Standard 10/12/2009

Registered optometry labour force DSS Health, Standard 10/12/2009

Registered osteopathy labour force DSS Health, Standard 10/12/2009

Registered pharmacy labour force DSS Health, Standard 10/12/2009

Registered physiotherapy labour force DSS Health, Standard 10/12/2009

Registered podiatry labour force DSS Health, Standard 10/12/2009

Registered psychology labour force DSS Health, Standard 10/12/2009

Residential mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Residential mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Country of employment in registered profession

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—country of employment in registered profession, Australia/other country code N
METeOR identifier:	383407
Registration status:	Health, Standard 10/12/2009
Definition:	The country in which a registered health professional is working in their profession, as represented by a code.
Data Element Concept:	Registered health professional—country of employment in registered profession

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Australia
	2	Other country
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 AUSTRALIA

The definition of Australia is based on the Standard Australian Classification of Countries (SACC). It includes Australia, Norfolk Island and Australian External Territories n.f.d.

CODE 2 OTHER COUNTRY

This includes all countries in the Standard Australian Classification of Countries (SACC) not included in Code 1 above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:

This data element is applicable to registered health professionals who are employed in the registered profession only.

Data is self-reported based on the country of employment in the registered profession in the week before registration.

Where a health professional works in their profession in Australia and another country, then code one should selected.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Labour force status cluster Health, Standard 10/12/2009

Creatine kinase MB isoenzyme level (index code)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatine kinase myocardial band isoenzyme level (measured), index code X[XXX]
Synonymous names:	Creatine kinase MB isoenzyme (CK-MB) - measured
METeOR identifier:	284903
Registration status:	Health, Standard 04/06/2004
Definition:	A person's measured creatine kinase myocardial band (CK-MB) isoenzyme level, as represented by an index.
Data Element Concept:	Person—creatine kinase-myocardial band isoenzyme level

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	X[XXX]
Maximum character length:	4

Supplementary values:

Value	Meaning
9999	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

CODE 88888 if test for CK-MB was not done on this admission.

Measured in different units dependent upon laboratory methodology.

When only one CK-MB level is recorded, this should be the peak level during admission.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:

Supersedes Creatine kinase MB isoenzyme (CK-MB) - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.0 KB)

Supersedes Creatine kinase MB isoenzyme (CK-MB) - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB)

See also Laboratory standard – upper limit of normal range for creatine kinase myocardial band isoenzyme, index code X[XXX] Health, Standard 04/06/2004

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Creatine kinase MB isoenzyme level (kCat per litre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatine kinase myocardial band isoenzyme level (measured), total kCat per litre N[NNN]
Synonymous names:	Creatine kinase MB isoenzyme (CK-MB) - measured
METeOR identifier:	284915
Registration status:	Health, Standard 04/06/2004
Definition:	A person's measured creatine kinase myocardial band (CK-MB) isoenzyme in kCat per litre.
Data Element Concept:	Person—creatine kinase-myocardial band isoenzyme level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
8888	Not measured
9999	Not stated/inadequately described

Unit of measure: Catalytic rate of an enzyme (kCat/L)

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: CODE 8888 if test for CK-MB was not done on this admission.

Measured in different units dependent upon laboratory methodology.

When only one CK-MB level is recorded, this should be the peak level during admission.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	See also Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total kCat per litre N[NNN] Health, Standard 04/06/2004
	Supersedes Creatine kinase MB isoenzyme (CK-MB) - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.0 KB)
	Supersedes Creatine kinase MB isoenzyme (CK-MB) - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008
	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Creatine kinase MB isoenzyme level (micrograms per litre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatine kinase-myocardial band isoenzyme level (measured), total micrograms per litre N[NNN]
METeOR identifier:	356833
Registration status:	Health, Standard 01/10/2008
Definition:	A person's measured creatine kinase-myocardial band (CK-MB) isoenzyme level in micrograms per litre.
Data Element Concept:	Person—creatine kinase-myocardial band isoenzyme level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
9998	Not measured
9999	Not stated/inadequately described

Unit of measure: Microgram per litre (µg/L)

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:

CODE 9998 if test for CK-MB was not done for this hospital presentation.

Measured in different units dependent upon laboratory methodology.

When only one CK-MB level is recorded, this should be the peak level.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Person—creatine kinase-myocardial band isoenzyme level (measured), total micrograms per litre N[NNNN] Health, Superseded 01/10/2008

	See also Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total micrograms per litre N[NNN] Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Creatine kinase MB isoenzyme level (nanograms per decilitre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatine kinase myocardial band isoenzyme level (measured), total nanograms per decilitre N[NNN]
Synonymous names:	Creatine kinase MB isoenzyme (CK-MB) - measured
METeOR identifier:	284923
Registration status:	Health, Standard 04/06/2004
Definition:	A person's measured creatine kinase myocardial band (CK-MB) isoenzyme in nanograms per decilitre.
Data Element Concept:	Person—creatine kinase-myocardial band isoenzyme level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
8888	Not measured
9999	Not stated/inadequately described

Unit of measure: Nanogram per decilitre (ng/dl)

Data element attributes

Collection and usage attributes

Guide for use:

CODE 8888 if test for CK-MB was not done on this admission.

Measured in different units dependent upon laboratory methodology.

When only one CK-MB level is recorded, this should be the peak level during admission.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:

Supersedes Creatine kinase MB isoenzyme (CK-MB) - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.0 KB)

	Supersedes Creatine kinase MB isoenzyme (CK-MB) - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008
	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Creatine kinase MB isoenzyme level (percentage)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatine kinase myocardial band isoenzyme level (measured), percentage N[NNN]
Synonymous names:	Creatine kinase MB isoenzyme (CK-MB) - measured
METeOR identifier:	284913
Registration status:	Health, Standard 04/06/2004
Definition:	A person's measured creatine kinase myocardial band (CK-MB) isoenzyme as a percentage.
Data Element Concept:	Person—creatine kinase-myocardial band isoenzyme level

Value domain attributes

Representational attributes

Representation class:	Percentage
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
8888	Not measured
9999	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	CODE 8888 if test for CK-MB was not done on this admission. Measured in different units dependent upon laboratory methodology. When only one CK-MB level is recorded, this should be the peak level during admission.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Creatine kinase MB isoenzyme (CK-MB) - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.0 KB)

Supersedes Creatine kinase MB isoenzyme (CK-MB) - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB)

See also Laboratory standard – upper limit of normal range for creatine kinase myocardial band isoenzyme, percentage N[NNN] Health, Standard 04/06/2004

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Creatine kinase MB isoenzyme level (units per litre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatine kinase-myocardial band isoenzyme level (measured), total units per litre N[NNN]
Synonymous names:	Creatine kinase MB isoenzyme (CK-MB) - measured
METeOR identifier:	356830
Registration status:	Health, Standard 01/10/2008
Definition:	A person's measured creatine kinase-myocardial band (CK-MB) isoenzyme level in units per litre.
Data Element Concept:	Person—creatine kinase-myocardial band isoenzyme level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
9998	Not measured
9999	Not stated/inadequately described

Unit of measure: Units per litre (U/L)

Data element attributes

Collection and usage attributes

Guide for use:

CODE 9998 if test for CK-MB was not done for this hospital presentation.

Measured in different units dependent upon laboratory methodology.

When only one CK-MB level is recorded, this should be the peak level.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

Supersedes Person—creatine kinase-myocardial band isoenzyme level (measured), total international units N[NNN] Health, Superseded 01/10/2008

See also Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total units per litre N[NNN] Health, Standard 01/10/2008

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Creatine kinase MB isoenzyme—upper limit of normal range (units per litre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total units per litre N[NNN]
METeOR identifier:	356596
Registration status:	Health, Standard 01/10/2008
Definition:	Laboratory standard for the value of creatine kinase myocardial band (CK-MB) isoenzyme measured in units per litre that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
9998	Not measured
9999	Not stated/inadequately described

Unit of measure: Units per litre (U/L)

Data element attributes

Collection and usage attributes

Guide for use: Record the upper limit of the creatine kinase myocardial band (CK-MB) normal reference range for the testing laboratory.

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group.

Relational attributes

Related metadata references: Supersedes Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total international units N[NNN] Health, Superseded 01/10/2008

See also Person—creatine kinase-myocardial band isoenzyme level (measured), total units per litre N[NNN] Health, Standard 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Creatine kinase MB isoenzyme—upper limit of normal range (index code)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, index code X[XXX]
Synonymous names:	Creatine kinase MB isoenzyme (CK-MB) - units
METeOR identifier:	284931
Registration status:	Health, Standard 04/06/2004
Definition:	Laboratory standard for the value of creatine kinase myocardial band (CK-MB) isoenzyme measured as an index that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	X[XXX]	
Maximum character length:	4	
Supplementary values:	Value	Meaning
	9999	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the creatine kinase myocardial band (CK-MB) normal reference range for the testing laboratory.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group.

Relational attributes

Related metadata references:	Supersedes Creatine kinase MB isoenzyme (CK-MB) - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB) See also Person—creatine kinase myocardial band isoenzyme level (measured), index code X[XXX] Health, Standard 04/06/2004
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008 Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Creatine kinase MB isoenzyme—upper limit of normal range (kCat per litre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total kCat per litre N[NNN]
METeOR identifier:	284963
Registration status:	Health, Standard 04/06/2004
Definition:	Laboratory standard for the value of creatine kinase myocardial band (CK-MB) isoenzyme in kCat per litre that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
8888	Not measured
9999	Not stated/inadequately described

Unit of measure: Catalytic rate of an enzyme (kCat/L)

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: Record the upper limit of the creatine kinase myocardial band (CK-MB) normal reference range for the testing laboratory.

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group.

Relational attributes

Related metadata references: Supersedes Creatine kinase MB isoenzyme (CK-MB) - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)

See also Person—creatine kinase myocardial band isoenzyme level (measured), total kCat per litre N[NNN] Health, Standard 04/06/2004

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008
	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Creatine kinase MB isoenzyme—upper limit of normal range (micrograms per litre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total micrograms per litre N[NNN]
METeOR identifier:	359287
Registration status:	Health, Standard 01/10/2008
Definition:	Laboratory standard for the value of creatine kinase myocardial band (CK-MB) isoenzyme measured in micrograms per litre that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
9998	Not measured
9999	Not stated/inadequately described

Unit of measure: Microgram per litre (µg/L)

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: Record the upper limit of the creatine kinase myocardial band (CK-MB) normal reference range for the testing laboratory.

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group.

Relational attributes

Related metadata references: Supersedes Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total micrograms per litre N[NNN] Health, Superseded 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Creatine kinase MB isoenzyme—upper limit of normal range (nanograms per decilitre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total nanograms per decilitre N[NNN]
METeOR identifier:	285957
Registration status:	Health, Standard 04/06/2004
Definition:	Laboratory standard for the value of creatine kinase myocardial band (CK-MB) isoenzyme measured in nanograms per decilitre that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
8888	Not measured
9999	Not stated/inadequately described

Unit of measure: Nanogram per decilitre (ng/dl)

Data element attributes

Collection and usage attributes

Guide for use: Record the upper limit of the creatine kinase myocardial band (CK-MB) normal reference range for the testing laboratory.

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group.

Relational attributes

Related metadata references: Supersedes Creatine kinase MB isoenzyme (CK-MB) - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.0 KB)

Supersedes Creatine kinase MB isoenzyme (CK-MB) - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008
	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Creatine kinase MB isoenzyme—upper limit of normal range (percentage)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, percentage N[NNN]
METeOR identifier:	284961
Registration status:	Health, Standard 04/06/2004
Definition:	Laboratory standard for the value of creatine kinase myocardial band (CK-MB) isoenzyme measured as a percentage that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme

Value domain attributes

Representational attributes

Representation class:	Percentage
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
8888	Not measured
9999	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the creatine kinase myocardial band (CK-MB) normal reference range for the testing laboratory.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group.

Relational attributes

Related metadata references:	See also Person—creatine kinase myocardial band isoenzyme level (measured), percentage N[NNN] Health, Standard 04/06/2004 Supersedes Creatine kinase MB isoenzyme (CK-MB) - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008
	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Creatine kinase isoenzyme—upper limit of normal range (U/L)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for creatine kinase isoenzyme, total units per litre N[NNN]
METeOR identifier:	349630
Registration status:	Health, Standard 01/10/2008
Definition:	Laboratory standard for the value of creatine kinase (CK) isoenzyme measured in units per litre that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for creatine kinase isoenzyme

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
9998	Not measured
9999	Not stated/inadequately described

Unit of measure: Units per litre (U/L)

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the creatine kinase normal reference range for the testing laboratory.
Comments:	There are three different CK isoenzyme sub-forms: - CK-MM (skeletal muscle) - CK-MB (cardiac muscle) - CK-BB (brain tissue)

Relational attributes

Related metadata references:	See also Person—creatine kinase isoenzyme level (measured), total units per litre N[NNN] Health, Standard 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Creatine kinase level (U/L)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatine kinase isoenzyme level (measured), total units per litre N[NNN]
Synonymous names:	CK measured (U/L)
METeOR identifier:	349536
Registration status:	Health, Standard 01/10/2008
Definition:	A person's measured creatine kinase (CK) isoenzyme level in units per litre.
Data Element Concept:	Person—creatine kinase isoenzyme level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
9998	Not measured
9999	Not stated/inadequately described

Unit of measure: Units per litre (U/L)

Data element attributes

Collection and usage attributes

Guide for use:

CODE 8888 if test for CK was not done for this hospital presentation.

Where possible, several CK measures should be recorded and their associated date and time. At a minimum, an initial, peak and late value should be recorded.

When only one CK level is recorded, this should be the peak level.

Comments:

Elevation of CK isoenzyme is an indication of damage to muscle.

There are three different CK isoenzyme sub-forms:

- CK-MM (skeletal muscle)
- CK-MB (cardiac muscle)
- CK-BB (brain tissue)

Relational attributes

Related metadata references:	See also Laboratory standard—upper limit of normal range for creatine kinase isoenzyme, total units per litre N[NNN] Health, Standard 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Creatinine serum level (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatinine serum level, total micromoles per litre NN[NN]
METeOR identifier:	360936
Registration status:	Health, Standard 01/10/2008
Definition:	A person's serum creatinine level measured in micromoles per litre.
Data Element Concept:	Person—creatinine serum level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	String
Format:	NN[NN]
Maximum character length:	4
Unit of measure:	Micromole per litre (µmol/L)

Data element attributes

Collection and usage attributes

Guide for use:	There is no agreed standard as to which units serum creatinine should be recorded in. Note: If the measurement is obtained in mmol/L it is to be multiplied by 1000.
Collection methods:	Measurement of creatinine should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority. • Single venous blood test taken at the time of other screening blood tests. • Fasting not required.
Comments:	Serum creatinine can be used to help determine renal function. Serum creatinine by itself is an insensitive measure of renal function because it does not increase until more than 50% of renal function has been lost. Serum creatinine together with a patient's age, weight and sex can be used to calculate glomerular filtration rate (GFR), which is an indicator of renal status/ function. The calculation uses the Cockcroft-Gault formula. Creatinine is normally produced in fairly constant amounts in the muscles, as a result the breakdown of phosphocreatine. It passes into the blood and is excreted in the urine. Serum creatinine can

be used to help determine renal function. The elevation in the creatinine level in the blood indicates disturbance in kidney function.

GFR decreases with age, but serum creatinine remains relatively stable. When serum creatinine is measured, renal function in the elderly tends to be overestimated, and GFR should be used to assess renal function, according to the Cockcroft-Gault formula:

$$\text{GFR (ml/min)} = \frac{(140 - \text{age [yrs]}) \times \text{body wt (kg)}}{814 \times \text{serum creatinine (mmol/l)}} \quad [\times 0.85 \text{ (for women)}]$$

An alternative formula is derived from the Modification of Diet in Renal Disease (MDRD) study and does not rely on knowledge of body weight:

GFR (ml/min/1.73m2) = 32788 x creatinine$^{-1.154}$ (umol/L) x age$^{-0.203}$ x (males: 1, females: 0.742).

To determine the degree of chronic renal impairment

GFR > 90ml/min - normal

GFR >60 - 90ml/min - mild renal impairment

GFR >30 - 60ml/min - moderate renal impairment

GFR 0 - 30 ml/min - severe renal impairment

Note: The above GFR measurement should be for a period greater than 3 months. GFR may also be assessed by 24-hour creatinine clearance adjusted for body surface area.

In general, patients with GFR < 30 ml/min are at high risk of progressive deterioration in renal function and should be referred to a nephrology service for specialist management of renal failure.

Patients should be assessed for the complications of chronic renal impairment including anaemia, hyperparathyroidism and be referred for specialist management if required.

Patients with rapidly declining renal function or clinical features to suggest that residual renal function may decline rapidly (ie. hypertensive, proteinuric (>1g/24hours), significant comorbid illness) should be considered for referral to a nephrologist well before function declines to less than 30ml/min. (Draft CARI Guidelines 2002. Australian Kidney Foundation). Patients in whom the cause of renal impairment is uncertain should be referred to a nephrologist for assessment.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

National Diabetes Data Working Group

Origin: Caring for Australians with Renal Impairment (CARI) Guidelines. Australian Kidney Foundation

Relational attributes

Related metadata references: Supersedes Person—creatinine serum level, micromoles per litre NN[NN] Health, Superseded 01/10/2008

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008
	Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Date C-reactive protein level measured

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—C-reactive protein level measured date, DDMMYYYY
Synonymous names:	CRP measured date
METeOR identifier:	338280
Registration status:	Health, Standard 01/10/2008
Definition:	The date a person's C-reactive protein (CRP) level is measured.
Data Element Concept:	Person—C-reactive protein level measured date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Collection methods:	The date C-reactive protein (CRP) is measured should be recorded from the laboratory report.

Relational attributes

Related metadata references:	See also Person—C-reactive protein level measured time, hhmm Health, Standard 01/10/2008 See also Person—C-reactive protein level (measured), total milligrams per litre N[NN].N Health, Standard 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Date accuracy indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Date—accuracy indicator, code AAA
METeOR identifier:	294429
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	An indicator of the accuracy of the components of a reported date, as represented by a code.
Data Element Concept:	Date—accuracy indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	AAA
Maximum character length:	3

Permissible values:

Value	Meaning
AAA	Day, month and year are accurate
AAE	Day and month are accurate, year is estimated
AAU	Day and month are accurate, year is unknown
AEE	Day is accurate, month and year are estimated
AEU	Day is accurate, month is estimated, year is unknown
AUU	Day is accurate, month and year are unknown
AUA	Day is accurate, month is unknown, year is accurate
AUE	Day is accurate, month is unknown, year is estimated
AEA	Day is accurate, month is estimated, year is accurate
EAA	Day is estimated, month and year are accurate
EAE	Day is estimated, month is accurate, year is estimated
EAU	Day is estimated, month is accurate, year is unknown
EEA	Day and month are estimated, year is accurate
EEE	Day, month and year are estimated
EEU	Day and month are estimated, year is unknown
EUA	Day is estimated, month is unknown, year is accurate

EUE	Day is estimated, month is unknown, year is estimated
EUU	Day is estimated, month and year are unknown
UAA	Day is unknown, month and year are accurate
UAE	Day is unknown, month is accurate, year is estimated
UAU	Day is unknown, month is accurate, year is unknown
UEA	Day is unknown, month is estimated, year is accurate
UEE	Day is unknown, month and year are estimated
UEU	Day is unknown, month is estimated, year is unknown
UUA	Day and month are unknown, year is accurate
UUE	Day and month are unknown, year is estimated
UUU	Day, month and year are unknown

Collection and usage attributes

Guide for use:

Any combination of the values A, E, U representing the corresponding level of accuracy of each date component of the reported date.

This data element consists of a combination of three codes, each of which denotes the accuracy of one date component:

A – the referred date component is accurate

E – the referred date component is not known but is estimated

U – the referred date component is not known and not estimated.

This data element contains positional fields (DMY) that reflects the order of the date components in the format (DDMMYYYY) of the reported date:

Field 1 (D) – refers to the accuracy of the day component;

Field 2 (M) – refers to the accuracy of the month component;

Field 3 (Y) – refers to the accuracy of the year component.

Data domain	Date component (for a format DDMMYYYY)		
	(D)ay	(M)onth	(Y)ear
Accurate	A	A	A
Estimated	E	E	E
Unknown	U	U	U

This data element is valid only for use with dates that are reported/exchanged in the format (DDMMYYYY).

Example 1: A date has been sourced from a reliable source and is known as accurate then the Date accuracy indicator should be informed as (AAA).

Example 2: If only the age of the person is known and there is no certainty of the accuracy of this, then the Date accuracy indicator should be informed as (UUE). That is the day and month are "unknown" and the year is "estimated".

Example 3: If a person was brought in unconscious to an emergency department of a hospital and the only information available was from a relative who was certain of the age and the birthday's 'month' then the Date accuracy indicator should be informed as (UAA). A year derived from an accurate month and accurate age is always an accurate year.

The Date accuracy indicator can be useful for operational purposes to indicate the level of accuracy that a date has been collected at any point in time. It can indicate whether the stored date needs to be followed up until it reaches the intended minimal required accuracy. For example, if a person was brought in unconscious to an emergency department of a hospital the level of accuracy of the date collected at that point may not be satisfactory. It is likely that the correct date of birth can be obtained at a later date. The Date accuracy indicator provides information on the accuracy of the entered dates that may require further action.

For future users of the data it may also be essential they know the accuracy of the date components of a reported date.

Data element attributes

Collection and usage attributes

Collection methods:

Collection constraints:

If constraints for the collection of the date are imposed, such as 'a valid date must be input in an information system for unknown date components', the Date accuracy indicator should be used along with the date as a way of avoiding the contamination of the valid dates with the same value on the respective date components.

Example:

Some jurisdictions use 0107YYYY and some use 0101YYYY when only the year is known. When month and year are known some use the 15th day as the date i.e. 15MMYYYY. Where this occurs in a data collection that is used for reporting or analysis purposes there will be dates in the collection with the attributes 0107YYYY etc that are accurate and some that are not accurate. Without a corresponding flag to determine this accuracy the analysis or report will be contaminated by those estimated dates.

Comments:

Provision of a date is often a mandatory requirement in data collections.

Most computer systems require a valid date to be recorded in a date field i.e. the month part must be an integer between 1 and 12, the day part must be an integer between 1 and 31 with rules about the months with less than 31 days, and the year part should include the century. Also in many systems, significant dates (e.g. date of birth) are mandatory requirements.

However, in actual practice, the date or date components are often not known (e.g. date of birth, date of injury) but, as stated above, computer systems require a valid date. This means that a date MUST be included and it MUST follow the rules for a valid date. It therefore follows that, while such a date will contain valid values according to the rules for a date, the date is in fact an 'unknown' or 'estimated' date. For future users of the data it is essential they know that a date is accurate, unknown or estimated and which components of the date are accurate, unknown or estimated.

Source and reference attributes

Submitting organisation: Standards Australia

Reference documents: AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia

Relational attributes

Related metadata references:

See also Individual service provider—occupation start date, DDMMYYYY Health, Standard 04/05/2005, Community services, Standard 30/09/2005

See also Individual service provider—occupation end date, DDMMYYYY Health, Standard 04/05/2005, Community services, Standard 30/09/2005

See also Person—date of birth, MMYYYY Health, Standard 10/12/2009

See also Person—date of birth, DDMMYYYY Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 20/06/2005

Implementation in Data Set Specifications:

Health care client identification DSS Health, Superseded 03/12/2008

Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Superseded 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Date creatine kinase MB isoenzyme measured

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatine kinase myocardial band isoenzyme measured date, DDMMYYYY
METeOR identifier:	284973
Registration status:	Health, Standard 04/06/2004
Definition:	The date on which the person's creatine kinase myocardial band isoenzyme (CK-MB) is measured.
Data Element Concept:	Person—creatine kinase myocardial band isoenzyme measured date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item pertains to the measuring of creatine kinase myocardial band (CK-MB) isoenzyme at any time point during this current event.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Date creatine kinase MB isoenzyme (CK-MB) measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.7 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008
	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005
	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Date creatinine serum level measured

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatinine serum level measured date, DDMMYYYY
METeOR identifier:	343843
Registration status:	Health, Standard 01/10/2008
Definition:	The date when the person's creatinine serum level was measured.
Data Element Concept:	Person—creatinine serum level measured date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Collection methods:	Record the date of the most recent creatinine serum level measurement taken in the last 12 months. Date to be recorded from documentation on the laboratory test results and/or the medical record.

Relational attributes

Related metadata references:	See also Person—creatinine serum level, micromoles per litre NN[NN] Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Date of acute coronary syndrome related clinical event

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with acute coronary syndrome—acute coronary syndrome related clinical event date, DDMMYYYY
METeOR identifier:	349645
Registration status:	Health, Standard 01/10/2008
Definition:	The date a person experienced an acute coronary syndrome related clinical event.
Data Element Concept:	Person with acute coronary syndrome—acute coronary syndrome related clinical event date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	A date should be recorded for each of the specified clinical events that the person experiences while in hospital.
Comments:	An acute coronary syndrome (ACS) related clinical event is a clinical event which can affect the health outcomes of a person with ACS. Information on the occurrence of these clinical events in people with ACS is required due to an emerging appreciation of their relationship with late mortality.

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome clinical event cluster Health, Standard 01/10/2008 *Conditional obligation:* If a clinical event has occurred, record the date when it was experienced by the person.

Date of birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—date of birth, DDMMYYYY
METeOR identifier:	287007
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 20/06/2005
Definition:	The date of birth of the person.
Data Element Concept:	Person—date of birth

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	If date of birth is not known or cannot be obtained, provision should be made to collect or estimate age. Collected or estimated age would usually be in years for adults, and to the nearest three months (or less) for children aged less than two years. Additionally, an estimated date flag or a date accuracy indicator should be reported in conjunction with all estimated dates of birth. For data collections concerned with children's services, it is suggested that the estimated date of birth of children aged under 2 years should be reported to the nearest 3 month period, i.e. 0101, 0104, 0107, 0110 of the estimated year of birth. For example, a child who is thought to be aged 18 months in October of one year would have his/her estimated date of birth reported as 0104 of the previous year. Again, an estimated date flag or date accuracy indicator should be reported in conjunction with all estimated dates of birth.
Collection methods:	Information on date of birth can be collected using the one question: What is your/(the person's) date of birth? In self-reported data collections, it is recommended that the following response format is used: Date of birth: _ _ / _ _ / _ _ _ _ This enables easy conversion to the preferred representational layout (DDMMYYYY).

For record identification and/or the derivation of other metadata items that require accurate date of birth information, estimated dates of birth should be identified by a date accuracy indicator to prevent inappropriate use of date of birth data. The linking of client records from diverse sources, the sharing of patient data, and data analysis for research and planning all rely heavily on the accuracy and integrity of the collected data. In order to maintain data integrity and the greatest possible accuracy an indication of the accuracy of the date collected is critical. The collection of an indicator of the accuracy of the date may be essential in confirming or refuting the positive identification of a person. For this reason it is strongly recommended that the data element Date—accuracy indicator, code AAA also be recorded at the time of record creation to flag the accuracy of the data.

Comments:

Privacy issues need to be taken into account in asking persons their date of birth.

Wherever possible and wherever appropriate, date of birth should be used rather than age because the actual date of birth allows a more precise calculation of age.

When date of birth is an estimated or default value, national health and community services collections typically use 0101 or 0107 or 3006 as the estimate or default for DDMM.

It is suggested that different rules for reporting data may apply when estimating the date of birth of children aged under 2 years because of the rapid growth and development of children within this age group which means that a child's development can vary considerably over the course of a year. Thus, more specific reporting of estimated age is suggested.

Source and reference attributes

Origin:

National Health Data Committee

National Community Services Data Committee

Reference documents:

AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia

AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references:

Supersedes Person—date of birth, DDMMYYYY Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005

See also Date—accuracy indicator, code AAA Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is used in the formation of Record—linkage key, code 581 XXXXXDDMMYYYYN Community services, Standard 21/05/2010

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v 6) NN Health, Standard 22/12/2009

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v 6) ANNA Health, Standard 22/12/2009

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA Health, Superseded 22/12/2009

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN Health, Superseded 22/12/2009

Is used in the formation of Episode of admitted patient care—length of stay (including leave days) (postnatal), total N[NN] Health, Standard 04/07/2007

Is used in the formation of Episode of admitted patient care—length of stay (including leave days) (antenatal), total N[NN] Health, Standard 04/07/2007

Is used in the formation of Episode of admitted patient care (postnatal)—length of stay (including leave days), total N[NN] Health, Superseded 04/07/2007

Is used in the formation of Episode of admitted patient care (antenatal)—length of stay (including leave days), total N[NN] Health, Superseded 04/07/2007

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Admitted patient palliative care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient palliative care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient palliative care NMDS 2007-08 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient palliative care NMDS 2008-09 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient palliative care NMDS 2009-10 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient palliative care NMDS 2010-11 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Alcohol and other drug treatment services NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Superseded 06/03/2009

Cancer (clinical) DSS Health, Superseded 22/12/2009

Cancer (clinical) DSS Health, Standard 22/12/2009

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Community mental health care 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Community mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Community mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Community mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Community mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Computer Assisted Telephone Interview demographic module DSS Health, Superseded 03/12/2008

Computer Assisted Telephone Interview demographic module DSS Health, Standard 03/12/2008

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Health care client identification DSS Health, Superseded 03/12/2008

Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Superseded 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Health labour force NMDS Health, Standard 01/03/2005

Implementation start date: 01/07/2005

Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Non-admitted patient emergency department care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Perinatal NMDS Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Perinatal NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Perinatal NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Residential mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Residential mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Date of cessation of treatment episode for alcohol and other drugs

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—treatment cessation date, DDMMYYYY
METeOR identifier:	270067
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a treatment episode for alcohol and other drugs ceases.
Data Element Concept:	Episode of treatment for alcohol and other drugs—treatment cessation date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

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 the glossary item **Cessation of treatment episode for alcohol and other drugs** to determine when a treatment episode ceases. The date must be later than or the same as the treatment commencement date for the episode of treatment for alcohol and other drugs.
Comments:	Required to identify the cessation of a treatment episode by an alcohol and other drug treatment service.

Source and reference attributes

Submitting organisation:	Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references:	Supersedes Date of cessation of treatment episode for alcohol and other drugs, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.6 KB)

Implementation in Data Set Specifications:

Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Alcohol and other drug treatment services NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Date of change to qualification status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care (newborn)—date of change to qualification status, DDMMYYYY
METeOR identifier:	270034
Registration status:	Health, Standard 01/03/2005
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.
Data Element Concept:	Episode of admitted patient care (newborn)—date of change to qualification status

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

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. Must be greater than or equal to admission date.

Relational attributes

Related metadata references:	Supersedes Date of change to qualification status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB) Is used in the formation of Episode of admitted patient care (newborn)—number of qualified days, total N[NNNN] Health, Standard 01/03/2005

Date of commencement of treatment episode for alcohol and other drugs

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—treatment commencement date, DDMMYYYY
METeOR identifier:	270069
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which the first service contact within the treatment episode when assessment and/or treatment occurs.
Data Element Concept:	Episode of treatment for alcohol and other drugs—treatment commencement date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage 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 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,
- their treatment delivery setting for alcohol and other drugs has changed.

Comments: Required to identify the commencement of a treatment episode by an alcohol and other drug treatment service.

Source and reference attributes

Submitting organisation:	Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references:

Supersedes Date of commencement of treatment episode for alcohol and other drugs, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Supersedes Commencement of treatment episode for alcohol and other drugs, version 2, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.5 KB)

Implementation in Data Set Specifications:

Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Alcohol and other drug treatment services NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Date of completion of last previous pregnancy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Pregnancy (last previous)—pregnancy completion date, DDMMYYYY
METeOR identifier:	270002
Registration status:	Health, Standard 01/03/2005
Definition:	Date on which the pregnancy preceding the current pregnancy was completed.
Data Element Concept:	Pregnancy (last previous)—pregnancy completion date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	Estimate day of month (DD), if first day is unknown.
Comments:	This metadata item is recommended by the World Health Organization. It is currently collected in some states and territories. Interval between pregnancies may be an important risk factor for the outcome of the current pregnancy, especially for preterm birth and low **birthweight**.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Date of completion of last previous pregnancy, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.6 KB)

Date of coronary artery bypass graft

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—coronary artery bypass graft date, DDMMYYYY
Synonymous names:	CABG date
METeOR identifier:	344424
Registration status:	Health, Standard 01/10/2008
Definition:	The date on which a coronary artery bypass graft (CABG) procedure is performed on a person.
Data Element Concept:	Person—coronary artery bypass graft date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	Record the date of each CABG if more than one has been performed. CABG includes grafts and valve replacement, but does not include valve replacement alone.
Collection methods:	The date/s should be recorded from the medical record.

Relational attributes

Implementation in Data Set Specifications:	Coronary artery cluster Health, Standard 01/10/2008 *Conditional obligation:* Record when a coronary artery bypass graft is performed.

Date of death

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—date of death, DDMMYYYY
METeOR identifier:	287305
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The date of death of the person.
Data Element Concept:	Person—date of death

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	Recorded for persons who have died. Where Date of birth is collected, Date of death must be equal to or greater than Date of birth for the same person.
Collection methods:	It is recommended that in cases where all components of the date of death 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. For record identification and/or the derivation of other metadata items that require accurate date of death information, estimated dates of death should be identified by a date accuracy indicator to prevent inappropriate use of date of death data. The linking of client records from diverse sources, the sharing of patient data, and data analysis for research and planning all rely heavily on the accuracy and integrity of the collected data. In order to maintain data integrity and the greatest possible accuracy an indication of the accuracy of the date collected is critical. The collection of Date accuracy indicator may be essential in confirming or refuting the positive identification of a person. For this reason it is strongly recommended that the data element Date accuracy indicator also be recorded at the time of record creation to flag the accuracy of the data.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Health Data Standards Committee

Relational attributes

Related metadata references:	Supersedes Date of death, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.5 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008
	Cancer (clinical) DSS Health, Superseded 07/12/2005
	Cancer (clinical) DSS Health, Superseded 06/03/2009
	Cancer (clinical) DSS Health, Superseded 22/12/2009
	Cancer (clinical) DSS Health, Standard 22/12/2009
	Health care provider identification DSS Health, Superseded 04/07/2007
	Health care provider identification DSS Health, Superseded 03/12/2008
	Health care provider identification DSS Health, Standard 03/12/2008

Date of diagnosis

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—diagnosis date, DDMMYYYY
METeOR identifier:	270544
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a patient is diagnosed with a particular condition or disease.
Data Element Concept:	Patient—diagnosis date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Comments:	Classification systems, which enable the allocation of a code to the diagnostic information, can be used in conjunction with this metadata item.

Source and reference attributes

Submitting organisation:	Cardiovascular Data Working Group

Relational attributes

Related metadata references:	Supersedes Date of diagnosis, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (13.9 KB)
Implementation in Data Set Specifications:	Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006
	Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007
	Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009
	Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Date of diagnosis of cancer

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—diagnosis date (cancer), DDMMYYYY
METeOR identifier:	270061
Registration status:	Health, Standard 01/03/2005
Definition:	The date when the cancer was first diagnosed (whether at its primary site or as a metastasis).
Context:	Patient administration system, cancer notification system, population cancer statistics, research.
Data Element Concept:	Patient—diagnosis date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	Date of diagnosis must be: >= date of birth <= date of death Diagnosis of cancer after death: If the patient is first diagnosed with the cancer in an autopsy report the date of diagnosis is the date of death as stated on the patient's death certificate. Incidental diagnosis of cancer: If a patient is admitted for another condition (for example a broken leg or pregnancy), and a cancer is diagnosed incidentally then the date of diagnosis is the date the cancer was diagnostically determined, not the admission date.
Collection methods:	Reporting rules: The date of diagnosis is the date of the pathology report, if any, that first confirmed the diagnosis of cancer. This date may be found attached to a letter of referral or a patient's medical record from another institution or hospital. If this date is unavailable, or if no pathological test was done, then the date may be determined from one of the sources listed in the following sequence:

Date of the consultation at, or admission to, the hospital, clinic or institution when the cancer was first diagnosed. Note: DO NOT use the admission date of the current admission if the patient had a prior diagnosis of this cancer.

Date of first diagnosis as stated by a recognised medical practitioner or dentist. Note: This date may be found attached to a letter of referral or a patient's medical record from an institution or hospital.

Date the patient states they were first diagnosed with cancer. Note: This may be the only date available in a few cases (for example, patient was first diagnosed in a foreign country).

If components of the date are not known, an estimate should be provided where possible with an estimated date flag to indicate that it is estimated. If an estimated date is not possible, a standard date of 15 June 1900 should be used with a flag to indicate the date is not known.

Source and reference attributes

Origin:

International agency for research on cancer

World Health Organisation

International Association of Cancer Registries

Reference documents:

Modified from the definition presented by the New South Wales Inpatient Statistics Collection Manual 2000/2001

Relational attributes

Related metadata references:

Supersedes Date of diagnosis of cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.3 KB)

Implementation in Data Set Specifications:

Breast cancer (Cancer registries) DSS Health, Standard 06/03/2009

Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Superseded 06/03/2009

Cancer (clinical) DSS Health, Superseded 22/12/2009

Cancer (clinical) DSS Health, Standard 22/12/2009

Date of diagnosis of first recurrence

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—diagnosis date (first recurrence of cancer), DDMMYYYY
METeOR identifier:	288596
Registration status:	Health, Standard 04/06/2004
Definition:	The date a medical practitioner confirms the diagnosis of a recurrent or metastatic cancer of the same histology.
Data Element Concept:	Patient—diagnosis date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	The term 'recurrence' defines the return, reappearance or metastasis of cancer (of the same histology) after a disease free period.
Comments:	This item is collected for determining the time interval from diagnosis to recurrence, from treatment to recurrence and from recurrence to death.

Source and reference attributes

Origin:	Commission on Cancer, American College of Surgeons
Reference documents:	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:	Supersedes Date of diagnosis of first recurrence, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.8 KB)
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Superseded 06/03/2009 Cancer (clinical) DSS Health, Superseded 22/12/2009 Cancer (clinical) DSS Health, Standard 22/12/2009

Date of diagnostic cardiac catheterisation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—diagnostic cardiac catheterisation date, DDMMYYYY
Synonymous names:	Date of coronary angiography
METeOR identifier:	359791
Registration status:	Health, Standard 01/10/2008
Definition:	The date when cardiac catheterisation is performed for diagnostic purposes.
Data Element Concept:	Person—diagnostic cardiac catheterisation date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item includes coronary angiography which is performed using a catheter.

Source and reference attributes

Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Date of electrocardiogram

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Electrocardiogram— electrocardiogram date, DDMMYYYY
Synonymous names:	Date of ECG
METeOR identifier:	343820
Registration status:	Health, Standard 01/10/2008
Definition:	The date an electrocardiogram (ECG) is performed for a person.
Data Element Concept:	Electrocardiogram—electrocardiogram date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Collection methods:	The date of ECG should be recorded irrespective of the setting (e.g. pre-hospital setting, emergency department or inpatient ward). The date of ECG should be recorded each time an ECG is performed.

Relational attributes

Implementation in Data Set Specifications:	Electrocardiogram cluster Health, Standard 01/10/2008

Date of first contact

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Community nursing service episode—first contact date, DDMMYYYY
METeOR identifier:	270190
Registration status:	Health, Standard 01/03/2005
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.
Data Element Concept:	Community nursing service episode—first contact date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:

This should occur after a previous last contact date of a previous care episode and prior to or on the same as first service delivery date.

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.

Excludes:

- first visits where the visit objective is not met, such as first visit made where no one is home.

Collection methods:

The first contact date can be the same as first service delivery date 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.

Comments:

This metadata 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.

To enable analysis of time periods throughout a care episode, especially the pre-admission period and associated activities. This metadata item enables the capture of the commencement of care irrespective of the setting in which the activities took place.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Relational attributes

Related metadata references: Supersedes Date of first contact, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.9 KB)

Date of first delivery of service

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care (community setting)—first service delivery date, DDMMYYYY
METeOR identifier:	270210
Registration status:	Health, Standard 01/03/2005
Definition:	The date of first delivery of service to a person in a non-institutional setting.
Data Element Concept:	Episode of care—first service delivery date (community setting)

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	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 Community nursing service episode—first contact date, DDMMYYYY.
Collection methods:	As long as contact is made with the person in a non-institutional setting, the Episode of care (community setting)—first service delivery date, DDMMYYYY 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.
Comments:	This metadata item 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. 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.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Relational attributes

Related metadata references: Supersedes Date of first delivery of service, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.2 KB)

Date of functional stress test

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Functional stress test—test date, DDMMYYYY
METeOR identifier:	347054
Registration status:	Health, Standard 01/10/2008
Definition:	The date when a functional stress test is performed on a person.
Data Element Concept:	Functional stress test—test date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	The date should always be recorded when a functional stress test is performed.

Relational attributes

Implementation in Data Set Specifications:	Functional stress test cluster Health, Standard 01/10/2008 *Conditional obligation:* To be provided when a functional stress test is performed.

Date of implantable cardiac defibrillator procedure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—implantable cardiac defibrillator procedure date, DDMMYYYY
Synonymous names:	ICD procedure date
METeOR identifier:	359611
Registration status:	Health, Standard 01/10/2008
Definition:	The date when a procedure is performed for insertion of an implantable cardiac defibrillator (ICD).
Data Element Concept:	Person—implantable cardiac defibrillator procedure date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Source and reference attributes

Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Date of intra-aortic balloon pump procedure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—intra-aortic balloon pump procedure date, DDMMYYYY
METeOR identifier:	359623
Registration status:	Health, Standard 01/10/2008
Definition:	The date when a procedure is performed for insertion of an intra-aortic balloon pump.
Data Element Concept:	Person—intra-aortic balloon pump procedure date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Source and reference attributes

Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Date of intravenous fibrinolytic therapy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—intravenous fibrinolytic therapy date, DDMMYYYY
METeOR identifier:	356921
Registration status:	Health, Standard 01/10/2008
Definition:	The date intravenous (IV) fibrinolytic therapy was first administered or initiated.
Data Element Concept:	Person—intravenous fibrinolytic therapy date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	If initiated by a bolus dose whether in a pre-hospital setting, emergency department or inpatient unit/ward, the date the initial bolus was administered should be recorded.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group

Relational attributes

Related metadata references:	Supersedes Person—intravenous fibrinolytic therapy date, DDMMYYYY Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008 *Conditional obligation:* If prescribed, provide the date when the fibrinolytic therapy is administered.

Date of last contact

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Community nursing service episode—last contact date, DDMMYYYY
METeOR identifier:	270191
Registration status:	Health, Standard 01/03/2005
Definition:	Date of the last contact between a staff member of the community service and a person in any setting.
Data Element Concept:	Community nursing service episode—last contact date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:

This could be the same as the date of discharge.

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.

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.

Comments:

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 metadata 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.

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.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Relational attributes

Related metadata references: Supersedes Date of last contact, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)

Date of most recent stroke

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—most recent stroke date, DDMMYYYY
Synonymous names:	CVA date
METeOR identifier:	338263
Registration status:	Health, Standard 01/10/2008
Definition:	The date of the most recent cerebrovascular accident or stroke experienced by a person.
Data Element Concept:	Person—most recent stroke date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Collection methods:	The date should be self-reported by the person or recorded by the clinician based on the notes in the medical record. The occurrence of a stroke should be evidenced by a record of cerebral imaging (CT or MRI).

Relational attributes

Related metadata references:	See also Person—clinical evidence status (stroke), code N Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Date of non-invasive ventilation administration

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—non-invasive ventilation administration date, DDMMYYYY
METeOR identifier:	359637
Registration status:	Health, Standard 01/10/2008
Definition:	The date when non-invasive ventilation is administered.
Data Element Concept:	Person—non-invasive ventilation administration date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Source and reference attributes

Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Date of onset of acute coronary syndrome symptoms

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—acute coronary syndrome symptoms onset date, DDMMYYYY
Synonymous names:	Date of onset of ACS symptoms
METeOR identifier:	321201
Registration status:	Health, Standard 01/10/2008
Definition:	The date on which a person experienced acute coronary syndrome symptoms that prompted the person to seek medical attention, either at the hospital or from a general practitioner.
Data Element Concept:	Person—acute coronary syndrome symptoms onset date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:

Acute coronary syndrome symptoms may include:

- tightness, pressure, heaviness, fullness or squeezing in the chest which may spread to the neck and throat, jaw, shoulders, the back, upper abdomen, either or both arms and even into the wrist and hands
- dyspnoea, nausea/vomiting, cold sweat or syncope.

Seeking medical attention could include the person presenting to their GP who then refers them to hospital or the person presenting directly to hospital (via ambulance or own form of transport).

If the person is already a patient at the hospital for another reason then the date would be when they advised hospital staff of their symptoms.

Collection methods:

Record the date that the person identifies as being when the most significant acute coronary syndrome symptom/s occurred that prompted them to seek medical attention.

Relational attributes

Related metadata references:

See also Person—acute coronary syndrome risk stratum, code N Health, Superseded 01/10/2008

	See also Person—acute coronary syndrome symptoms onset time, hhmm Health, Standard 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Date of pacemaker insertion

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—pacemaker insertion date, DDMMYYYY
METeOR identifier:	359591
Registration status:	Health, Standard 01/10/2008
Definition:	The date when a procedure is performed for insertion of a pacemaker.
Data Element Concept:	Person—pacemaker insertion date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Source and reference attributes

Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Date of primary percutaneous coronary intervention

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—primary percutaneous coronary intervention date, DDMMYYYY
Synonymous names:	Primary PCI date
METeOR identifier:	359175
Registration status:	Health, Standard 01/10/2008
Definition:	Date of the primary percuatenous coronary intervention (PCI).
Data Element Concept:	Person—primary percutaneous coronary intervention date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	Primary PCI relates to the first balloon angioplasty inflation and/or stent implantation for reperfusion therapy of a ST-segment-elevation myocardial infarction (STEMI). The date or the first balloon angioplasty inflation should be recorded, even if this includes implantation of a stent.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group

Relational attributes

Related metadata references:	Supersedes Person—first angioplasty balloon inflation or stenting date, DDMMYYYY Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Coronary artery cluster Health, Standard 01/10/2008 *Conditional obligation:* Record when a primary percutaneous coronary intervention is performed.

Date of procedure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care (procedure)—procedure commencement date, DDMMYYYY
METeOR identifier:	270298
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a procedure commenced during an inpatient episode of care.
Data Element Concept:	Episode of admitted patient care (procedure)—procedure commencement date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	Admitted patients: Record date of procedure for all procedures undertaken during an episode of care in accordance with the current edition of ICD-10-AM.
Collection methods:	Date of procedure >= admission date Date of procedure <= separation date
Comments:	The National Centre for Classification in Health advises the Health Data Standards Committee of relevant changes to the ICD-10-AM. Required to provide information on the timing of the procedure in relation to the episode of care.

Source and reference attributes

Origin:	National Centre for Classification in Health National Health Data Committee
Reference documents:	Australian Institute of Health and Welfare (AIHW) 2000. Australian hospital statistics 1998-1999. AIHW cat. no. HSE 11. Canberra: AIHW (Health Services Series no. 15)

Relational attributes

Related metadata references:	Supersedes Date of procedure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Date of referral to rehabilitation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health service event—referral to rehabilitation service date, DDMMYYYY
METeOR identifier:	269993
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a person is referred to a rehabilitation service.
Data Element Concept:	Health service event—referral to rehabilitation service date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	If date of referral is not known then provision should be made to collect month and year as a minimum, using 01 as DD (as the date part) if only the month and year are known.
Collection methods:	To be collected at the time of commencement of rehabilitation.

Source and reference attributes

Submitting organisation:	Cardiovascular Data Working Group

Relational attributes

Related metadata references:	Supersedes Date of referral to rehabilitation, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.2 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008
	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005
	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008
	Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006
	Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007
	Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009

Date of rescue percutaneous coronary intervention

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—rescue percutaneous coronary intervention date, DDMMYYYY
Synonymous names:	Rescue PCI date
METeOR identifier:	359580
Registration status:	Health, Standard 01/10/2008
Definition:	The date when rescue percutaneous coronary intervention (PCI) is performed.
Data Element Concept:	Person—rescue percutaneous coronary intervention date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	Rescue PCI relates to balloon angioplasty inflation and/or stent implantation performed following failed fibrinolysis in patients with continuing or recurrent myocardial ischaemia.

Source and reference attributes

Reference documents:	National Heart Foundation of Australia & Cardiac Society of Australia and New Zealand. Guidelines for the management of acute coronary syndromes 2006. Med J Aust 2006; 184; S1-S32. © MJA 2006

Relational attributes

Implementation in Data Set Specifications:	Coronary artery cluster Health, Standard 01/10/2008 *Conditional obligation:* Record when a rescue percutaneous coronary intervention is performed.

Date of revascularisation percutaneous coronary intervention

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—revascularisation percutaneous coronary intervention date, DDMMYYYY
Synonymous names:	Revascularisation PCI date
METeOR identifier:	359731
Registration status:	Health, Standard 01/10/2008
Definition:	The date when a percutaneous coronary intervention (PCI) is performed for revascularisation.
Data Element Concept:	Person—revascularisation percutaneous coronary intervention date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	Revascularisation PCI relates to balloon angioplasty inflation and/or stent implantation performed for subsequent restoration of blood flow.
Comments:	Routine revascularisation PCI may be performed after ST-segment-elevation myocardial infarction for people with objective evidence of recurrent myocardial infarction in whom there is spontaneous or inducible ischaemia or haemodynamic instability. Revascularisation PCI may also be performed for treatment of high-risk non-ST-segment-elevation acute coronary syndrome.

Source and reference attributes

Reference documents:	National Heart Foundation of Australia & Cardiac Society of Australia and New Zealand. Guidelines for the management of acute coronary syndromes 2006. Med J Aust 2006; 184; S1-S32. © MJA 2006

Relational attributes

Implementation in Data Set Specifications:	Coronary artery cluster Health, Standard 01/10/2008 *Conditional obligation:* Record when a percutaneous coronary intervention is performed for revascularisation.

Date of surgical treatment for cancer

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—surgical procedure date, DDMMYYYY
METeOR identifier:	288632
Registration status:	Health, Standard 04/06/2004
Definition:	The date on which the cancer-directed surgical treatment was performed.
Data Element Concept:	Cancer treatment—surgical procedure date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	The date of each surgical treatment episode should be entered separately. Collected for curative and palliative surgery prior to the first recurrence.

Source and reference attributes

Submitting organisation:	National Cancer Control Initiative
Origin:	Commission on Cancer, American College of Surgeons
Reference documents:	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:	Supersedes Date of surgical treatment for cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.5 KB)
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Superseded 06/03/2009 Cancer (clinical) DSS Health, Superseded 22/12/2009 Cancer (clinical) DSS Health, Standard 22/12/2009

Date of triage

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—triage date, DDMMYYYY
METeOR identifier:	313815
Registration status:	Health, Standard 07/12/2005
Definition:	The date on which the patient is **triaged**.
Data Element Concept:	Non-admitted patient emergency department service episode—triage date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Collection methods:	Collected in conjunction with non-admitted patient emergency department service episode—**triage** time.

Source and reference attributes

Submitting organisation:	Australian Government Department of Health and Ageing

Relational attributes

Related metadata references:	Supersedes Triage—triage date, DDMMYYYY Health, Superseded 07/12/2005
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008 Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008 Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Non-admitted patient emergency department care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Date of ventricular ejection fraction test

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Ventricular ejection fraction test—test date, DDMMYYYY
Synonymous names:	Date EF measured
METeOR identifier:	344274
Registration status:	Health, Standard 01/10/2008
Definition:	The date when a person's ventricular ejection fraction is measured.
Data Element Concept:	Ventricular ejection fraction test—test date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Relational attributes

Implementation in Data Set Specifications:	Ventricular ejection fraction cluster Health, Standard 01/10/2008 *Conditional obligation:* To be provided when the ventricular ejection fraction is measured.

Date patient presents

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health service event—presentation date, DDMMYYYY
METeOR identifier:	270393
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which the patient/client presents for the delivery of a service.
Data Element Concept:	Health service event—presentation date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

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 date 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), 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 service commencement date).

Source and reference attributes

Submitting organisation:	National Institution Based Ambulatory Model Reference Group
Origin:	National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Date patient presents, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.3 KB)

Is used in the formation of Non-admitted patient emergency department service episode—waiting time (to service delivery),

total minutes NNNNN Health, Superseded 22/12/2009

Is used in the formation of Non-admitted patient emergency department service episode—service episode length, total minutes NNNNN Health, Standard 01/03/2005

Is used in the formation of Non-admitted patient emergency department service episode—waiting time (to hospital admission), total hours and minutes NNNN Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Non-admitted patient emergency department care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Date troponin measured

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—troponin level measured date, DDMMYYYY
METeOR identifier:	359422
Registration status:	Health, Standard 01/10/2008
Definition:	Date the person's troponin assay is measured.
Data Element Concept:	Person—troponin level measured date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item pertains to the measuring of troponin at any time point during this current event.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Person—troponin level measured date, DDMMYYYY Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Day program attendances

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of day centre attendances, total N[NNNN]
METeOR identifier:	270245
Registration status:	Health, Standard 01/03/2005
Definition:	A count of the number of patient/client visits to day centres.
Data Element Concept:	Establishment—number of day centre attendances

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNN]
Maximum character length:	5
Unit of measure:	Attendance

Data element attributes

Collection and usage attributes

Comments:

This metadata item is derived from components that are not currently specified in METeOR, but which are recorded in various ways by hospitals and/or outpatient departments. Examples include identifiers of individual consultations/visits, diagnostic tests, etc.

Required to measure adequately non-admitted patient services in psychiatric hospitals and alcohol and drug hospitals.

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.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Day program attendances, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)

Degree of spread of cancer

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—degree of spread of a cancer, code N
METeOR identifier:	270180
Registration status:	Health, Standard 01/03/2005
Definition:	Degree of spread of cancer is a measure of the progression/extent of cancer at a particular point in time, as represented by a code.
Data Element Concept:	Person with cancer—degree of spread of a cancer

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Localised to the tissue of origin
2	Invasion of adjacent tissue or organs
3	Regional lymph nodes
4	Distant metastases
5	Not Applicable
Supplementary values: 9	Unknown

Collection and usage attributes

Guide for use: The valid values for the variable are listed below.

CODE 1 Localised to the tissue of origin

Includes a primary cancer where the spread is contained within the organ of origin. Note: this includes in situ breast (D05.0-D05.9) and in situ melanoma (D03.0-D03.9)

Example 1: For colon cancer, the cancer has not progressed into the adventitia (peritoneal layer) surrounding the colon.

Example 2: For breast cancer, the cancer has not progressed into the underlying muscle layer (pectoral) or externally to the skin.

Example 3: For melanoma of the skin, the cancer has not invaded the subcutaneous fat layer (that is, it is contained within the dermis and epidermis).

Example 4: For lung cancer, the cancer has not invaded the pleura.

CODE 2 Invasion of adjacent tissue or organs

A primary cancer has spread to adjacent organs or tissue not forming part of the organ of origin. This category includes

sub-cutaneous fat or muscle and organs adjacent to the primary cancer site.

Example 1: For colon cancer, the cancer has progressed into the adventitia (peritoneal layer) surrounding the colon.

Example 2:For breast cancer, the degree of spread has progressed into the underlying muscle layer (pectoral) or externally into the skin.

Example 3: For melanoma of the skin, the cancer has invaded into subcutaneous fat or muscle.

Example 4: For lung cancer, the cancer has invaded the pleura or tissues of the mediastinum.

CODE 3 Regional lymph nodes

The primary cancer has metastasised to the nearby draining lymph nodes. The list below shows the regional lymph nodes by site of primary cancer (International Union Against Cancer's definition).

Head and neck - Cervical nodes

Larynx - Cervical nodes

Thyroid - Cervical and upper mediastinal nodes

Stomach - Perigastric nodes along the lesser and greater curvatures

Colon and Rectum - Pericolic, perirectal, and those located along the ileocolic, right colic, middle colic, left colic, inferior mesenteric and superior rectal

Anal - Perirectal, internal iliac, and inguinal lymph nodes

Liver - Hilar nodes, e.g. the hepatoduodenal ligament

Pancreas - Peripancreatic nodes

Lung - Intrathoracic, scalene and supraclavicular

Breast - Axillary, interpectoral, internal mammary

Cervix - Paracervical, parametrial, hypogastric, common, internal and external iliac, presacral and sacral

Ovary - Hypogastric (obturator), common iliac, external iliac, lateral, sacral, para-aortic and inguinal

Prostate and bladder - Pelvic nodes below the bifurcation of the common iliac arteries

Testes - Abdominal, para-aortic and paracaval nodes, the intrapelvic and inguinal nodes

Kidney - Hilar, abdominal, para-aortic or paracaval.

CODE 4 Distant metastases

The primary cancer has spread to sites distant to the primary site, for example liver and lung and bone, or any lymph nodes not stated as regional to the site (see '3 - Regional lymph nodes' above).

CODE 5 Not applicable

This category applies for lymphatic and haematopoietic cancers, e.g. myelomas, leukaemias and lymphomas (C81.0 - C96.9) only.

CODE 9 Unknown

No information is available on the degree of spread at this episode or the available information is insufficient to allow classification into one of the preceding categories.

Data element attributes

Source and reference attributes

Submitting organisation: World Health Organization
New South Wales Health Department

Origin: International Classification of Diseases for Oncology, Second Edition (ICD-O-2) New South Wales Inpatient Statistics Collection Manual-2000/2001

Relational attributes

Related metadata references: Supersedes Degree of spread of cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.6 KB)

Department of Veterans' Affairs file number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—government funding identifier, Department of Veterans' Affairs file number AAXXNNNNA
METeOR identifier:	339127
Registration status:	Health, Standard 29/11/2006 Community services, Standard 31/08/2007
Definition:	A unique personal identifier issued to a veteran by the Department of Veterans' Affairs.
Data Element Concept:	Person—government funding identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	AAXXNNNN[A]
Maximum character length:	9

Collection and usage attributes

Guide for use:

1st character is the state code (an alphabetic character) - N, V, Q, W, S or T for the appropriate state/territory. Australian Capital Territory is included in New South Wales (N) and Northern Territory with South Australia (S).

Next 7 characters are the file number, made up of:
War code + numeric digits, where:
if War code is 1 alphabetic character, add 6 numeric characters (ANNNNNN)

Where there is no war code as is the case with World War 1 veterans, insert a blank and add 6 numeric characters (NNNNNN)

if War code is 2 alphabetic characters, add 5 numeric characters (AANNNNN)
if War code is 3 alphabetic characters, add 4 numeric characters (AAANNNN)

The 9th character is the segment link. For dependents of veterans, the 9th character is always an alphabetic character. The alphabetic code is generated in the order by which the cards are issued. For example A, B, C, D etc.

CAUTIONARY NOTE: For veterans the 9th character is left blank

Data element attributes

Collection and usage attributes

Collection methods:

The Department of Veterans' Affairs file number should only be collected from persons eligible to receive health services that are to be funded by the DVA. The number may be reported to the appropriate government agency to reconcile payment for the service provided.

DVA card number:

This number is the digitised version of the file number. If paper claims are optically scanned by the Health Insurance Commission, the digitised version of the file number is picked up by the scanner and converted to the normal file number format. For manual claims, the gold and white cards may be used in conjunction with the data element and an imprinter. This method records the DVA file number and other card details on a manual voucher.

The data should not be used by private sector organisations for any purpose unless specifically authorised by law. For example, private sector organisations should not use the DVA file number for data linking unless specifically authorised by relevant privacy legislation.

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.

Comments:

All veterans and veteran community clients are issued with a DVA file number. The veteran community may access many different benefits, ranging from pensions to health services, through their DVA file number.

Note that Veterans may have a Medicare card number and a Department of Veterans Affairs (DVA) number or only a DVA number.

DVA has three (3) types of health cards:

- Gold Card
- White Card
- Repatriation Pharmaceutical Benefits Card.

Each card indicates, to the health provider, the level of health services the holder is eligible for, at the DVA expense.

The Gold card enables the holder to access a comprehensive range of health care and related services, for all conditions, whether they are related to war service or not.

The White card enables the holder to access health care and associated services for war or service-related conditions. Veterans of Australian forces may also be issued this card to receive treatment for malignant cancer, pulmonary tuberculosis and post traumatic stress disorder and, for Vietnam veterans only, anxiety or depression, irrespective of whether these conditions are related to war service or not.

The white card holders are eligible to receive, for specific conditions, treatment from registered medical, hospital, pharmaceutical, dental and allied health care providers with whom DVA has arrangements.

A white card is also issued to eligible ex-service personnel who are from other countries, which enter into arrangements with the Australian government for the treatment of the conditions that these countries accept as war related.

When a gold/white card holder accesses health services at DVA expense, the DVA File Number is critical and should be used. The person's Medicare card number is not required or relevant.

It should be noted that there are a number of gold card holders who do not have a Medicare card.

The Repatriation Pharmaceutical Benefits card is an orange coloured card issued to eligible veterans and merchant mariners from Britain and the Commonwealth and other allied countries. This card enables the holder to access the range of pharmaceutical items available under the Repatriation Pharmaceutical Benefits Scheme. It does not provide access to other health services.

Source and reference attributes

Origin: Department of Veterans' Affairs

Relational attributes

Related metadata references: Supersedes Person—government funding identifier, Department of Veterans' Affairs file number AAXXNNNN[A] Health, Superseded 29/11/2006

Department of Veterans' Affairs patient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—funding eligibility indicator (Department of Veterans Affairs), code N
METeOR identifier:	270092
Registration status:	Health, Standard 01/03/2005
Definition:	Whether an eligible person's charges for this hospital **admission** are met by the Department of Veterans' Affairs (DVA), as represented by a code.
Context:	Health services
Data Element Concept:	Episode of care—funding eligibility indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:	Refer to the Veterans' Entitlements Act 1986 for details of eligible DVA beneficiaries.
Collection methods:	Whether or not charges for this episode of care are met by the DVA is routinely established as part of hospital admission processes.
Comments:	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 DVA. 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.

To assist in analyses of utilisation and health care funding.

Relational attributes

Related metadata references:

Supersedes Department of Veterans' Affairs patient, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.9 KB)

Implementation in Data Set Specifications:

Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Non-admitted patient emergency department care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Dependency in activities of daily living—bathing

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (bathing), code N
METeOR identifier:	270413
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a person's need for assistance with bathing, as represented by a code.
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.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Independent
2	Requires observation or rare physical assistance
3	Cannot perform the activity without some assistance
4	Full assistance required (totally dependent)

Data element attributes

Collection and usage attributes

Guide for use:	Services may elect to adopt the measures as defined in this metadata 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.
Collection methods:	Commencement of care episode (there may be several visits in which assessment data are gathered).
Comments:	There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use. The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:	Australian Council of Community Nursing Services
Reference documents:	ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:	Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—bed mobility

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (bed mobility), code N
METeOR identifier:	270416
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the level of a person's need for assistance with bed mobility, as represented by a code.
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.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Independent
2	Requires observation or rare physical assistance
3	Cannot perform the activity without some assistance
4	Full assistance required (totally dependent) - a hoist is used
5	2 persons physical assist is required

Data element attributes

Collection and usage attributes

Guide for use:	Services may elect to adopt the measures as defined in this metadata 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. Code 4: A hoist is used. Code 5: 2 persons physical assist is required.
Collection methods:	Commencement of care episode (there may be several visits in which assessment data are gathered).
Comments:	There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use. The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:	Australian Council of Community Nursing Services
Reference documents:	ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:	Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—bladder continence

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (bladder continence), code N
METeOR identifier:	270417
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the level of a person's bladder continence, as represented by a code.
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.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
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

Data element attributes

Collection and usage attributes

Guide for use:

Services may elect to adopt the measures as defined in this metadata 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.

Collection methods:

Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments:

There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Reference documents:

ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:

Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—bowel continence

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (bowel continence), code N
METeOR identifier:	270418
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the level of a person's bowel continence, as represented by a code.
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.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
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

Data element attributes

Collection and usage attributes

Guide for use:	Services may elect to adopt the measures as defined in this metadata 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.
Collection methods:	Commencement of care episode (there may be several visits in which assessment data are gathered).
Comments:	There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use. The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:	Australian Council of Community Nursing Services
Reference documents:	ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:	Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—day-time technical nursing care requirement

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—technical nursing care requirement (day-time), total minutes NNN
METeOR identifier:	270420
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a person's need for day-time technical nursing care per week measured in minutes.
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.
Data Element Concept:	Person—technical nursing care requirement

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	NNN	
Maximum character length:	3	
Supplementary values:	Value	Meaning
	1	No technical care requirements
Unit of measure:	Minute (m)	

Data element attributes

Collection and usage attributes

Guide for use:	Record the minutes of day-time technical care required per week. 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.

Services may elect to adopt the measures as defined in this metadata 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.

Collection methods: Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments: There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Reference documents: ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references: Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—dressing

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (dressing), code N
METeOR identifier:	270414
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a person's need for assistance with dressing, as represented by a code.
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.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Independent
2	Requires observation or rare physical assistance
3	Cannot perform the activity without some assistance
4	Full assistance required (totally dependent)

Data element attributes

Collection and usage attributes

Guide for use:	Services may elect to adopt the measures as defined in this metadata 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.
Collection methods:	Commencement of care episode (there may be several visits in which assessment data are gathered).
Comments:	There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use. The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:	Australian Council of Community Nursing Services
Reference documents:	ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:	Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—eating

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (eating), code N
METeOR identifier:	270415
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a person's need for assistance with eating, as represented by a code.
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.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Independent
2	Requires observation or rare physical assistance
3	Cannot perform the activity without some assistance
4	Full assistance required (totally dependent)
5	Tube-fed only

Data element attributes

Collection and usage attributes

Guide for use:	Services may elect to adopt the measures as defined in this metadata 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.
Collection methods:	Commencement of care episode (there may be several visits in which assessment data are gathered).
Comments:	There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use. The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:	Australian Council of Community Nursing Services
Reference documents:	ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:	Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—evening technical nursing care requirement

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—technical nursing care requirement (evening), total minutes NNN
METeOR identifier:	270421
Registration status:	Health, Standard 01/03/2005
Definition:	A person's need for evening technical nursing care per week measured in minutes.
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.
Data Element Concept:	Person—technical nursing care requirement

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	NNN	
Maximum character length:	3	
Supplementary values:	Value	Meaning
	1	No technical care requirements
Unit of measure:	Minute (m)	

Data element attributes

Collection and usage attributes

Guide for use:	Record the minutes of evening technical care required per week. 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.

Services may elect to adopt the measures as defined in this metadata 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.

Collection methods: Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments: There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Reference documents: ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references: Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—extra surveillance

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (extra surveillance), code N
METeOR identifier:	270419
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a person's need for additional individual attention and/or planned intervention in carrying out activities of daily living, as represented by a code.
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.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
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

Data element attributes

Collection and usage attributes

Guide for use:

Extra surveillance refers to behaviour, which requires individual attention and/or planned intervention. Some examples are:

- aggressiveness
- wandering
- impaired memory or attention
- disinhibition and other cognitive impairment.

Services may elect to adopt the measures as defined in this metadata 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.

Collection methods:

Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments:

There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Reference documents:

ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:

Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—infrequent technical nursing care requirement

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—technical nursing care requirement (infrequent), total minutes NNN
METeOR identifier:	270423
Registration status:	Health, Standard 01/03/2005
Definition:	A person's need for infrequent technical nursing care per month measured in minutes.
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.
Data Element Concept:	Person—technical nursing care requirement

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	NNN	
Maximum character length:	3	
Supplementary values:	Value	Meaning
	1	No technical care requirements
Unit of measure:	Minute (m)	

Data element attributes

Collection and usage attributes

Guide for use:	Record the minutes of infrequent technical care required 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.

Services may elect to adopt the measures as defined in this metadata 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.

Collection methods: Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments: There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Reference documents: ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references: Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—mobility

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (mobility), code N
METeOR identifier:	270410
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a person's need for assistance with mobility, as represented by a code.
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.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Independent
2	Requires observation or rare physical assistance
3	Cannot perform the activity without some assistance
4	Full assistance required (totally dependent)

Data element attributes

Collection and usage attributes

Guide for use:	Applies to walking, walking aid or wheelchair. Services may elect to adopt the measures as defined in this metadata 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.
Collection methods:	Commencement of care episode (there may be several visits in which assessment data are gathered).
Comments:	There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use. The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:	Australian Council of Community Nursing Services
Reference documents:	ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCN

Relational attributes

Related metadata references:	Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—night-time technical nursing care requirement

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—technical nursing care requirement (night-time), total minutes NNN
METeOR identifier:	270422
Registration status:	Health, Standard 01/03/2005
Definition:	A person's need for night-time technical nursing care per week measured in minutes.
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.
Data Element Concept:	Person—technical nursing care requirement

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	NNN	
Maximum character length:	3	
Supplementary values:	Value	Meaning
	1	No technical care requirements
Unit of measure:	Minute (m)	

Data element attributes

Collection and usage attributes

Guide for use:	Record the minutes of night-time technical care required per week. 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.

Services may elect to adopt the measures as defined in this metadata 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.

Collection methods: Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments: There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Reference documents: ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references: Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—toileting

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (toileting), code N
METeOR identifier:	270411
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a person's need for assistance with toileting, as represented by a code.
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.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Independent
2	Requires observation or rare physical assistance
3	Cannot perform the activity without some assistance
4	Full assistance required (totally dependent)

Data element attributes

Collection and usage attributes

Guide for use:	Services may elect to adopt the measures as defined in this metadata 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.
Collection methods:	Commencement of care episode (there may be several visits in which assessment data is gathered).
Comments:	There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in the Guide for Use. The Person - Dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Reference documents:	ACCNS 1997. Community nursing minimum data set Australian version 2.0: data dictionary and guidelines. Melbourne: ACCNS.

Relational attributes

Related metadata references:	Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—transferring

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (transferring), code N
METeOR identifier:	270412
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a person's need for assistance with transferring, as represented by a code.
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.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Independent
2	Requires observation or rare physical assistance
3	Cannot perform the activity without some assistance
4	Full assistance required (totally dependent)
5	Person is bedfast

Data element attributes

Collection and usage attributes

Guide for use:	Services may elect to adopt the measures as defined in this metadata 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. Code 5: Person is bedfast.
Collection methods:	Commencement of care episode (there may be several visits in which assessment data are gathered).
Comments:	There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use. The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:	Australian Council of Community Nursing Services
Reference documents:	ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:	Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Diabetes status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—diabetes mellitus status, code NN
METeOR identifier:	270194
Registration status:	Health, Standard 01/03/2005
Definition:	Whether a person has or is at risk of diabetes, as represented by a code.
Data Element Concept:	Person—diabetes mellitus status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Type 1 diabetes
02	Type 2 diabetes
03	Gestational diabetes mellitus (GDM)
04	Other (secondary diabetes)
05	Previous gestational diabetes mellitus (GDM)
06	Impaired fasting glucose (IFG)
07	Impaired glucose tolerance (IGT)
08	Not diagnosed with diabetes
09	Not assessed

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Note that where there is a Gestational diabetes mellitus (GDM) or Previous GDM (i.e. permissible values 3 & 5) and a current history of Type 2 diabetes then record 'Code 2' Type 2 diabetes.

This same principle applies where a history of either Impaired fasting glycaemia (IFG) or Impaired glucose tolerance (IGT) and a current history and Type 2 diabetes, then record 'Code 2' Type 2 diabetes.

CODE 01 Type 1 diabetes

Beta-cell destruction, usually leading to absolute insulin deficiency. Includes those cases attributed to an autoimmune process, as well as those with beta-cell destruction and who are prone to ketoacidosis for which neither an aetiology nor pathogenesis is known (idiopathic). It does not include those

forms of beta-cell destruction or failure to which specific causes can be assigned (e.g. cystic fibrosis, mitochondrial defects). Some subjects with Type 1 diabetes can be identified at earlier clinical stages than 'diabetes mellitus'.

CODE 02 Type 2 diabetes

Type 2 includes the common major form of diabetes, which results from defect(s) in insulin secretion, almost always with a major contribution from insulin resistance.

CODE 03 Gestational diabetes mellitus (GDM)

GDM is a carbohydrate intolerance resulting in hyperglycaemia of variable severity with onset or first recognition during pregnancy. The definition applies irrespective of whether or not insulin is used for treatment or the condition persists after pregnancy. Diagnosis is to be based on the Australian Diabetes in Pregnancy Society (ADIPS) Guidelines.

CODE 04 Other (secondary diabetes)

This categorisation include less common causes of diabetes mellitus, but are those in which the underlying defect or disease process can be identified in a relatively specific manner. They include, for example, genetic defects of beta-cell function, genetic defects in insulin action, diseases of the exocrine pancreas, endocrinopathies, drug or chemical-induced, infections, uncommon forms of immune-mediated diabetes, other genetic syndromes sometimes associated with diabetes.

CODE 05 Previous GDM

Where the person has a history of GDM.

CODE 06 Impaired fasting glycaemia (IFG)

IFG or 'non-diabetic fasting hyperglycaemia' refers to fasting glucose concentrations, which are lower than those required to diagnose diabetes mellitus but higher than the normal reference range. An individual is considered to have IFG if they have a fasting plasma glucose of 6.1 or greater and less than 7.0 mmol/L if challenged with an oral glucose load, they have a fasting plasma glucose concentration of 6.1 mmol/L or greater, but less than 7.0 mmol/L, AND the 2 hour value in the Oral Glucose Tolerance Test (OGTT) is less than 7.8 mmol/L.

CODE 07 Impaired glucose tolerance (IGT)

IGT is categorised as a stage in the natural history of disordered carbohydrate metabolism; subjects with IGT have an increased risk of progressing to diabetes. IGT refers to a metabolic state intermediate between normal glucose homeostasis and diabetes. Those individuals with IGT manifest glucose intolerance only when challenged with an oral glucose load. IGT is diagnosed if the 2 hour value in the OGTT is greater than 7.8 mmol/L. and less than 11.1 mmol/L AND the fasting plasma glucose concentration is less than 7.0 mmol/L.

CODE 08 Not diagnosed with diabetes

The subject has no known diagnosis of Type 1, Type 2, GDM, Previous GDM, IFG, IGT or Other (secondary diabetes).

CODE 09 Not assessed

The subject has not had their diabetes status assessed.

CODE 99 Not stated/inadequately described

This code is for unknown or information unavailable.

Collection methods: The diagnosis is derived from and must be substantiated by clinical documentation.

Source and reference attributes

Origin: Developed based on Definition, Diagnosis and Classification of Diabetes Mellitus and its Complications Part 1: Diagnosis and Classifications of Diabetes Mellitus Provisional Report of a World Health Organization Consultation (Alberti & Zimmet 1998).

Data element attributes

Collection and usage attributes

Collection methods: Diabetes (clinical):

A type of diabetes should be recorded and coded for each episode of patient care.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

National Diabetes Data Working Group

Relational attributes

Related metadata references: Supersedes Diabetes status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (27.3 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Diabetes therapy type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—diabetes therapy type, code NN
METeOR identifier:	270236
Registration status:	Health, Standard 01/03/2005
Definition:	The type of diabetes therapy the person is currently receiving, as represented by a code.
Data Element Concept:	Person—diabetes therapy type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Diet and exercise only
02	Oral hypoglycaemic - sulphonylurea only
03	Oral hypoglycaemic - biguanide (eg metformin) only
04	Oral hypoglycaemic - alpha-glucosidase inhibitor only
05	Oral hypoglycaemic - thiazolidinedione only
06	Oral hypoglycaemic - meglitinide only
07	Oral hypoglycaemic - combination (eg biguanide & sulphonylurea)
08	Oral hypoglycaemic - other
09	Insulin only
10	Insulin plus oral hypoglycaemic
98	Nil - not currently receiving diabetes treatment

Supplementary values:

99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 01 Diet & exercise only

This code includes the options of generalised prescribed diet; avoid added sugar/simple carbohydrates (CHOs); low joule diet; portion exchange diet and uses glycaemic index and a recommendation for increased exercise.

CODE 98 Nil - not currently receiving diabetes treatment

This code is used when there is no current diet, tablets or insulin therapy(ies).

CODE 99 Not stated/inadequately described

Use this code when missing information.

Data element attributes

Collection and usage attributes

Collection methods: To be collected at the commencement of treatment and at each review.

Comments: In settings where the monitoring of a person's health is ongoing and where management can change over time (such as general practice), the Service contact—service contact date, DDMMYYYY should be recorded.

The main use of this data element is to enable categorisation of management regimes against best practice for diabetes.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Cardiovascular Data Working Group

Reference documents: Berkow R, editor. The Merck Manual. 16th ed. Rahway (New Jersey, USA): Merck Research Laboratories; 1992.

Relational attributes

Related metadata references: Supersedes Diabetes therapy type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.1 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Diagnosis related group

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—diagnosis related group, code (AR-DRG v 6) ANNA
METeOR identifier:	391295
Registration status:	Health, Standard 22/12/2009
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, as represented by a code.
Data Element Concept:	Episode of admitted patient care—diagnosis related group

Value domain attributes

Representational attributes

Classification scheme:	Australian Refined Diagnosis Related Groups version 6
Representation class:	Code
Data type:	String
Format:	ANNA
Maximum character length:	4

Data element attributes

Collection and usage attributes

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. The data elements required are described in Related data elements.

Source and reference attributes

Origin:	National Centre for Classification in Health

Relational attributes

Related metadata references:	See also Episode of admitted patient care—major diagnostic category, code (AR-DRG v 6) NN Health, Standard 22/12/2009
	Supersedes Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA Health, Superseded 22/12/2009
	Is formed using Person—sex, code N Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 10/02/2006
	Is formed using Episode of admitted patient care—separation date, DDMMYYYY Health, Standard 01/03/2005
	Is formed using Episode of admitted patient care—separation mode, code N Health, Standard 01/03/2005

Is formed using Episode of admitted patient care—intended length of hospital stay, code N Health, Standard 01/03/2005

Is formed using Episode of admitted patient care—admission date, DDMMYYYY Health, Standard 01/03/2005

Is formed using Person—date of birth, DDMMYYYY Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 20/06/2005

Is formed using Person—weight (measured), total grams NNNN Health, Standard 01/03/2005

Is formed using Episode of admitted patient care—number of leave days, total N[NN] Health, Standard 01/03/2005

Is formed using Episode of care—mental health legal status, code N Health, Standard 01/03/2005

Is formed using Episode of admitted patient care—procedure, code (ACHI 7th edn) NNNNN-NN Health, Standard 22/12/2009

Is formed using Episode of care—principal diagnosis, code (ICD-10-AM 7th edn) ANN{.N[N]} Health, Standard 22/12/2009

Is formed using Episode of care—additional diagnosis, code (ICD-10-AM 7th edn) ANN{.N[N]} Health, Standard 22/12/2009

Implementation in Data Set Specifications:

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Admitted patient mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Difficulty with activities

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—level of difficulty with activities in life areas, code (ICF 2001) N
METeOR identifier:	320120
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The level of difficulty a person has in performing the tasks and actions involved in specified life areas, as represented by a code.
Context:	Human functioning and disability
Data Element Concept:	Person—level of difficulty with activities in a life area

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Functioning, Disability and Health 2001
Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
0	No difficulty
1	Mild difficulty
2	Moderate difficulty
3	Severe difficulty
4	Complete difficulty

Supplementary values:

8	Not specified
9	Not applicable

Collection and usage attributes

Guide for use:

This metadata item contributes to the definition of the concept **'Disability'** and gives an indication of the experience of disability for a person.

In the context of health, an activity is the execution of a task or action by an individual. Activity limitations are difficulties an individual may have in executing an activity.

Difficulties with activities can arise when there is a qualitative or quantitative alteration in the way in which these activities are carried out. Difficulty includes matters such as 'with pain', 'time taken', 'number of errors', 'clumsiness', 'modification of manner in which an activity is performed' e.g. sitting to get dressed instead of standing. 'Difficulty' is a combination of the frequency

with which the problem exists, the duration of the problem and the intensity of the problem. Activity limitations are assessed against a generally accepted population standard, relative to cultural and social expectations.

Activity limitation varies with the environment and is assessed in relation to a particular environment; the absence or presence of **assistance**, including aids and equipment, is an aspect of the environment.

The user will select the code that most closely summarises, in terms of duration, frequency, manner or outcome, the level of difficulty of the person for whom the data is recorded.

CODE 0 No difficulty in this life area

Is used when there is no difficulty in performing this activity. This scale has a margin of error of 5%. [0-4%]

CODE 1 Mild difficulty

Is recorded for example, when the level of difficulty is below the threshold for medical intervention, the difficulty is experienced less than 25% of the time, and/or with a low alteration in functioning which may happen occasionally over the last 30 days. [5-24%]

CODE 2 Moderate difficulty

Is used for example when the level of difficulty is experienced less than 50% of the time and/or with a significant, but moderate effect on functioning (Up to half the scale of total performance) which may happen regularly over the last 30 days. [25-49%]

CODE 3 Severe difficulty

Is used for example when performance in this life area can be achieved, but with only extreme difficulty, and/or with an extreme effect on functioning which may happen often over the last 30 days. [50-95%]

CODE 4 Complete difficulty

Is used when the person can not perform in this life area due of the difficulty in doing so. This scale has a margin of error of 5%. [96-100%]

CODE 8 Not specified

Is used where a person has difficulty with activities in a life area but there is insufficient information to use codes 0-4.

CODE 9 Not applicable

Is used where a life area is not applicable to this person, e.g. domestic life for a child under 5.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.
Origin:	WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents: Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website http://www.who.int/classifications/icf/en/
- Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.cfm

Data element attributes

Collection and usage attributes

Guide for use: This data element, in conjunction with Person—activities and participation life area, code (ICF 2001) AN[NNN], indicates the presence and extent of activity limitation in a given domain of activity.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references: See also Person—activity and participation life area, code (ICF 2001) AN[NNN] Health, Standard 29/11/2006, Community services, Standard 16/10/2006

Implementation in Data Set Specifications: Activities and Participation cluster Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Division of General Practice number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Division of general practice—organisation identifier, NNN
METeOR identifier:	270014
Registration status:	Health, Standard 01/03/2005
Definition:	The unique identifier for the Division of general practice number as designated by the Commonwealth Government of Australia. Each separately administered Division of general practice has a unique identifying number.
Data Element Concept:	Division of general practice—organisation identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	Number
Format:	NNN
Maximum character length:	3

Data element attributes

Source and reference attributes

Submitting organisation:	Cardiovascular Data Working Group
Origin:	The actual Division of General Practice numbers can be obtained by selecting the individual State or Territory from the *Divisions Directory* found within the Australian Division of General Practice website

Relational attributes

Related metadata references:	Supersedes Division of general practice number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.2 KB)
Implementation in Data Set Specifications:	Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006
	Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007
	Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009
	Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Dyslipidaemia treatment indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dyslipidaemia treatment with anti-lipid medication indicator (current), code N
METeOR identifier:	302440
Registration status:	Health, Standard 21/09/2005
Definition:	Whether a person is being currently treated for dyslipidaemia using anti-lipid medication, as represented by a code.
Data Element Concept:	Person—dyslipidaemia treatment with anti-lipid medication indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 9 Not stated/inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use: CODE 1 Yes: Record if a person is being treated for dyslipidaemia using anti-lipid medication.

CODE 2 No: Record if a person is not being treated for dyslipidaemia using anti-lipid medication.

Collection methods: Ask the individual if he/she is currently treated with anti-lipid medication. Alternatively obtain the relevant information from appropriate documentation.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:	Supersedes Person—dyslipidaemia treatment status (anti-lipid medication), code N Health, Superseded 21/09/2005
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008
	Diabetes (clinical) DSS Health, Standard 21/09/2005

ECG—Q waves indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—electrocardiogram Q waves indicator, yes/no code N
METeOR identifier:	347711
Registration status:	Health, Standard 01/10/2008
Definition:	An indicator of whether Q waves are present on a person's follow-up electrocardiogram (ECG), as represented by a code.
Data Element Concept:	Person— electrocardiogram Q waves indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	Code 1 Yes Record if Q waves are identified on the follow-up electrocardiogram. Code 2 No Record if no Q waves are identified on the follow-up electrocardiogram.
Collection methods:	Do not record the presence of Q waves for the initial ECG. This data element should only be collected for follow-up ECGs.

Relational attributes

Related metadata references:	See also Electrocardiogram—new Q waves indicator, yes/no code N Health, Standard 01/10/2008
Implementation in Data Set Specifications:	Electrocardiogram cluster Health, Standard 01/10/2008 *Conditional obligation:*

Record for all follow up electrocardiograms performed after the initial electrocardiogram.

Electrocardiogram—new Q waves indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Electrocardiogram—new Q waves indicator, yes/no code N
Synonymous names:	ECG - new Q waves
METeOR identifier:	343902
Registration status:	Health, Standard 01/10/2008
Definition:	Whether the Q waves identified on a person's follow-up electrocardiogram (ECG) is new, as represented by a code.
Data Element Concept:	Electrocardiogram—new Q waves indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 9 Not stated/inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes (New Q waves)

Use this code where the follow-up ECG identifies Q waves >=0.03 seconds in width and >=1mm (0.1mV) in depth in at least 2 contiguous leads that were not seen on the initial ECG

CODE 2 No (Pre-existing Q waves)

Use this code where the follow-up ECG identifies Q waves >=0.03 seconds in width and >=1mm (0.1mV) in depth in at least 2 contiguous leads that were already seen on the initial ECG

CODE 9 Not stated/inadequately described

Includes unknown

Collection methods:

Do not record whether the Q waves are new or not on the initial ECG. This data element should only be recorded for follow-up ECGs.

Comments:

This data element identifies if new Q waves are present on the follow-up ECG. This information is valuable in coding transmural myocardial infarction.

Relational attributes

Related metadata references:

See also Person—electrocardiogram Q waves indicator, yes/no code N Health, Standard 01/10/2008

Implementation in Data Set Specifications:

Electrocardiogram cluster Health, Standard 01/10/2008

Conditional obligation:
Record if Q waves are present on the follow up electrocardiogram.

Electrocardiogram—ST-segment-elevation in lead V4R

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Electrocardiogram— ST-segment-elevation in lead V4R indicator, yes/no code N
Synonymous names:	ECG - ST-segment-elevation lead V4R
METeOR identifier:	343889
Registration status:	Health, Standard 01/10/2008
Definition:	An indicator of whether ST-segment-elevation of greater than or equal to 1mm (0.1mV) in lead V4R of the electrocardiogram (ECG) is present, as represented by a code.
Data Element Concept:	Electrocardiogram—electrocardiogram ST-segment-elevation in lead V4R indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 9 Not stated/inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes

ST-segment-elevation >= 1 mm (0.1 mV) in lead V4R

CODE 2 No

ST-segment-elevation in lead V4R of <= 1 mm (0.1 mV) or no ST-segment-elevation in lead V4R

CODE 9 Not stated/inadequately described

Includes unknown

Collection methods:

The presence (or absence) of ST-segment elevation in lead V4R should be recorded when right-sided precordial leads are performed in the ECG.

Comments: ST-segment elevation in lead V4R represents right ventricular infarction.

Relational attributes

Related metadata references: See also Electrocardiogram—lead V4R presence indicator, yes/no code N Health, Standard 01/10/2008

Implementation in Data Set Specifications: Electrocardiogram cluster Health, Standard 01/10/2008

Conditional obligation:
Record when lead V4R was performed on the electrocardiogram.

Electrocardiogram—lead V4R presence indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Electrocardiogram—lead V4R presence indicator, yes/no code N
Synonymous names:	ECG - lead V4R indicator
METeOR identifier:	349656
Registration status:	Health, Standard 01/10/2008
Definition:	An indicator of whether lead V4R was performed on a person's electrocardiogram (ECG), as represented by a code.
Data Element Concept:	Electrocardiogram—lead V4R presence indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Comments:	Lead V4R represents a lead placed on the chest aligned with the right mid-clavicular line, in the 5th intercostal space. The measurements from this lead can identify right ventricular infarction. Lead V4R should be performed in the context of inferior infarction, especially in the presence of haemodynamic compromise.

Relational attributes

Related metadata references:	See also Electrocardiogram— ST-segment-elevation in lead V4R indicator, yes/no code N Health, Standard 01/10/2008
Implementation in Data Set Specifications:	Electrocardiogram cluster Health, Standard 01/10/2008

Electrocardiogram change location

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Electrocardiogram—change location, code N
METeOR identifier:	356835
Registration status:	Health, Standard 01/10/2008
Definition:	The area in which the change is located on the electrocardiogram (ECG), as represented by a code.
Data Element Concept:	Electrocardiogram—change location

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Inferior leads: II, III, aVF
2	Anterior leads: V1 to V4
3	Lateral leads: I, aVL, V5 to V6
4	True posterior: V1 V2

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 4 True posterior: V1 V2

True posterior is relevant only for tall R waves.

Data element attributes

Collection and usage attributes

Guide for use: More than one code may be recorded.

Report in order of significance.

Where a change is located in all leads of the ECG codes 1, 2 and 3 should be recorded.

Record all codes that apply (code 9 is excluded from multiple coding).

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group

Relational attributes

Related metadata references:	Supersedes Person—electrocardiogram change location, code N Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Electrocardiogram cluster Health, Standard 01/10/2008

Electrocardiogram change type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Electrocardiogram—change type, code N
METeOR identifier:	356856
Registration status:	Health, Standard 01/10/2008
Definition:	The type of change to the heart rhythm seen on a person's electrocardiogram (ECG), as represented by a code.
Data Element Concept:	Electrocardiogram—change type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
10	ST-segment-elevation >= 1 mm (0.1 mV) in >= 2 contiguous limb leads
11	ST-segment-elevation >= 2 mm (0.2 mV) in >= 2 contiguous chest leads
12	ST-segment depression >= 0.5 mm (0.05 mV) in >= 2 contiguous leads (includes reciprocal changes)
20	T-wave inversion >= 2 mm (0.1 mV)
30	Significant Q waves
40	Left bundle-branch block (BBB)
41	Right bundle-branch block (BBB)
42	Indeterminate bundle-branch block (BBB)
90	Non specific

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Collection and usage attributes

Guide for use: ST-segment changes

CODE 10 ST-segment-elevation >= 1 mm (0.1 mV) in >= 2 contiguous limb leads

ST-segment-elevation indicates greater than or equal to 1 mm (0.1 mV) elevation in 2 or more contiguous limb leads.

CODE 11 ST-segment-elevation >= 2 mm (0.2 mV) in >= 2 contiguous chest leads

ST-segment-elevation indicates greater than or equal to 2 mm (0.2 mV) elevation in 2 or more contiguous chest leads.

CODE 12 ST-segment depression >= 0.5 mm (0.05 mV) in >= 2 contiguous leads (includes reciprocal changes)

ST-segment depression of at least 0.5 mm (0.05 mV) in 2 or more contiguous leads (includes reciprocal changes).

T-wave changes

CODE 20 T-wave inversion >= 2 mm (0.2 mV)

T-wave inversion of at least 2 mm (0.2 mV) including inverted T waves that are not indicative of acute MI.

Q wave changes

CODE 30 Significant Q waves

Q waves refer to the presence of Q waves that are greater than or equal to 0.03 seconds in width and greater than or equal to 1 mm (0.1 mV) in depth in at least 2 contiguous leads.

Bundle-branch block changes

CODE 40 Left bundle branch block (BBB)

Diffuse left bundle-branch block pattern.

CODE 41 Right bundle-branch block (BBB)

Diffuse right bundle-branch block pattern.

CODE 42 Indeterminate bundle-branch block (BBB)

Bundle-branch block pattern identified, but left or right location is unclear.

CODE 90 Non-specific

Changes not meeting the above criteria.

CODE 99 Not stated/inadequately described

Includes unknown.

Data element attributes

Collection and usage attributes

Guide for use:

More than one code may be recorded.

Record all that apply (codes 90 and 99 are excluded from multiple coding).

Collection methods:

Where codes 40, 41 or 42 are recorded Electrocardiogram - bundle-branch block status, code N must also be recorded.

Source and reference attributes

Submitting organisation:

Acute coronary syndrome data working group

Relational attributes

Related metadata references:

Supersedes Person—electrocardiogram change type, code N Health, Superseded 01/10/2008

Implementation in Data Set Specifications:

Electrocardiogram cluster Health, Standard 01/10/2008

Electronic communication address (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—electronic communication address, text [X(250)]
Synonymous names:	Electronic communication details
METeOR identifier:	287469
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	A unique combination of characters used as input to electronic communication equipment for the purpose of contacting a person, as represented by text.
Data Element Concept:	Person (address)—electronic communication address

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(250)]
Maximum character length:	250

Data element attributes

Collection and usage attributes

Guide for use:

Multiple electronic communication addresses (for example, multiple phone numbers, fax numbers and e-mail) may be recorded as required. Each instance should have an appropriate Electronic communication medium and usage code assigned.

Universal Resource Locator (URL)

One form of electronic address used as a locator for an internet-based web site.

Example: http://www.aihw.gov.au This is the full address, however, it is not essential to record 'http://www' as the commonly used internet browsers assume these characters are included. Therefore, the URL address could be recorded as 'aihw.gov.au'.

Email addresses

Email addresses are a combination of a username and an internet domain name (URL) joined by an @ symbol. The use of the full URL is not valid in an email address.

Example: myuserid@bigpond.net.au

Telephone numbers

- Record the prefix plus telephone number. For example, 08 8226 6000 or 0417 123456.

- Do not record punctuation in telephone numbers. For example, (08) 8226 6000 or 08-8226 6000 would not be correct.

Unknown contact details

Leave the field blank.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS 4846 Health Care Provider Identification, 2004, Sydney: Standards Australia
Reference documents:	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia
	AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

Implementation in Data Set Specifications:	Health care client identification DSS Health, Superseded 03/12/2008
	Health care client identification DSS Health, Standard 03/12/2008
	Health care provider identification DSS Health, Superseded 04/07/2007
	Health care provider identification DSS Health, Superseded 03/12/2008
	Health care provider identification DSS Health, Standard 03/12/2008

Electronic communication address (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—electronic communication address, text [X(250)]
METeOR identifier:	287480
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	A unique combination of characters used as input to electronic communication equipment for the purpose of contacting an organisation, as represented by text.
Data Element Concept:	Service provider organisation (address)—electronic communication address

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(250)]
Maximum character length:	250

Data element attributes

Collection and usage attributes

Guide for use:

Multiple electronic communication addresses (for example, multiple phone numbers, fax numbers and e-mail) may be recorded as required. Each instance should have an appropriate Electronic communication medium and usage code assigned.

Universal Resource Locator (URL)

One form of electronic address used as a locator for an internet-based web site.

Example: http://www.aihw.gov.au This is the full address, however, it is not essential to record 'http://www' as the commonly used internet browsers assume these characters are included. Therefore, the URL address could be recorded as 'aihw.gov.au'.

Email addresses

Email addresses are a combination of a username and an internet domain name (URL) joined by an @ symbol. The use of the full URL is not valid in an email address.

Example: myuserid@bigpond.net.au

Telephone numbers

Record the prefix plus telephone number. For example, 08 8226 6000 or 0417 123456.
Do not record punctuation in telephone numbers. For example, (08) 8226 6000 or 08-8226 6000 would not be correct.
Unknown contact details

Leave the field blank.

Source and reference attributes

Submitting organisation: Standards Australia

Origin: AS 4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Reference documents: AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia

In AS5017 this data element is represented by 'Telephone number (client)'. In AS4846 this data element is represented by 'Provider electronic communication details'. Refer to the current standard for more details.

Relational attributes

Implementation in Data Set Specifications: Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Superseded 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Electronic communication medium (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—electronic communication medium, code N
METeOR identifier:	287519
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	A type of communication mechanism used by a person, as represented by a code.
Data Element Concept:	Person (address)—electronic communication medium

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Telephone (excluding mobile telephone)
2	Mobile (cellular) telephone
3	Facsimile machine
4	Pager
5	e-mail
6	URL
8	Other

Data element attributes

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS 4846 Health Care Provider Identification, 2004, Sydney: Standards Australia
Reference documents:	AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

Implementation in Data Set Specifications:	Health care client identification DSS Health, Superseded 03/12/2008
	Health care client identification DSS Health, Standard 03/12/2008
	Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Superseded 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Electronic communication medium (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—electronic communication medium, code N
METeOR identifier:	287521
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	A type of communication mechanism used by an organisation, as represented by a code.
Data Element Concept:	Service provider organisation (address)—electronic communication medium

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Telephone (excluding mobile telephone)
2	Mobile (cellular) telephone
3	Facsimile machine
4	Pager
5	e-mail
6	URL
8	Other

Data element attributes

Collection and usage attributes

Guide for use:	Multiple electronic communication addresses (for example, multiple phone numbers, fax numbers and e-mail) may be recorded as required. Each instance should have an appropriate Electronic communication medium and Electronic communication usage code assigned.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS 4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Reference documents:

AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

In AS4846 alternative alphabetic codes are presented. Refer to the current standard for more details.

Relational attributes

Implementation in Data Set Specifications:

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Superseded 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Electronic communication usage code (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—electronic communication usage, code N
METeOR identifier:	287579
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The manner of use that a person applies to an electronic communication address, as represented by a code.
Data Element Concept:	Person (address)—electronic communication usage code

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Business use only
2	Personal use only
3	Both business and personal use

Data element attributes

Collection and usage attributes

Guide for use:	Only applicable to individuals, and not organisations.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	AS 4846 Health Care Provider Identification, 2004, Sydney: Standards Australia
Reference documents:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia In AS5017 an alternative data element is presented as 'Telephone number type (client)'. In AS4846 this data element is called 'Provider electronic communication type'. In both instances alternative alphabetic codes are presented. Refer to the current standard for more details.

Relational attributes

Implementation in Data Set Specifications:	Health care client identification DSS Health, Superseded 03/12/2008
	Health care client identification DSS Health, Standard 03/12/2008
	Health care provider identification DSS Health, Superseded 04/07/2007
	Health care provider identification DSS Health, Superseded 03/12/2008
	Health care provider identification DSS Health, Standard 03/12/2008

Emergency department arrival mode—transport

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—transport mode (arrival), code N
METeOR identifier:	270000
Registration status:	Health, Standard 01/03/2005
Definition:	The mode of transport by which the person arrives at the emergency department, as represented by a code.
Data Element Concept:	Non-admitted patient emergency department service episode—transport mode

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Ambulance, air ambulance or helicopter rescue service
2	Police/correctional services vehicle
8	Other

Supplementary values:

Value	Meaning
9	Not stated/unknown

Collection and usage attributes

Guide for use: CODE 8 Other

Includes walking, private transport, public transport, community transport, and taxi.

Data element attributes

Source and reference attributes

Submitting organisation: National reference group for non-admitted patient data development, 2001-02

Relational attributes

Related metadata references: Supersedes Emergency department arrival mode - transport, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.8 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Non-admitted patient emergency department care NMDS

Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Non-admitted patient emergency department care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Emergency department date of commencement of service event

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—service commencement date, DDMMYYYY
METeOR identifier:	390398
Registration status:	Health, Standard 22/12/2009
Definition:	The date on which a non-admitted emergency department service event commences.
Context:	Emergency Department care
Data Element Concept:	Non-admitted patient emergency department service episode—service commencement date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:

An Emergency Department service event can be commenced by a doctor, nurse, mental health practitioner or other health professional, when investigation, care and/or treatment is provided in accordance with an established clinical pathway defined by the Emergency Department. Placement of a patient in a cubicle and observations taken to monitor a patient pending a clinical decision regarding commencement of a clinical pathway, do not constitute commencement.

The following examples illustrate the commencement of an Emergency Department service event.

Example 1

- A patient presents at the Emergency Department with mild asthma. At triage, the patient is categorised as category three and returns to the waiting area.
- The patient has a more severe asthma attack in the waiting area, is re-triaged to category two and shown to a cubicle where standard observations are taken.
- A nurse comes to the cubicle and commences treatment based on an acknowledged clinical pathway of the

Emergency Department. At this point : **Emergency Department service event has commenced.**

Example 2

- A patient presents at the Emergency Department in an agitated, delusional state. At triage, the patient is categorised as category two and placed in a cubicle and the mental health practitioner notified.
- Observations are taken and nursing staff continue to observe the patient.
- The mental health practitioner arrives, assesses the patient and develops a management plan. At this point : **Emergency Department service event has commenced.**

Example 3

- A patient presents at the Emergency Department with an ankle injury from football. At triage, the patient is categorised as category four and moved to the 'fast track area'.
- The physiotherapist attends, examines the patient, makes an assessment (including diagnostic imaging requirements) and determines a treatment plan. At this point : **Emergency Department service event has commenced.**

Example 4

- A patient presents at the Emergency Department with a sore arm, following a fall, with limited arm movement possible.
- The patient is categorised as category three at triage and placed in a cubicle.
- A nurse provides analgesia and assesses the patient, including ordering diagnostic imaging. At this point : **Emergency Department service event has commenced.**

Example 5

- A patient presents at the Emergency Department feeling vague and having been generally unwell for a day or two. The patient has a slight cough. At triage, the patient is categorised as category three.
- The patient is placed in a cubicle where standard observations are taken. Respiration is 26 bpm, BP is 90/60 and the patient is hypoxic. The patient is given oxygen, and the treating clinician attends and provides instruction regarding patient care. At this point : **Emergency Department service event has commenced.**

Example 6

- A patient presents at the Emergency Department with chest pain. Triage category two is allocated. The patient is placed in a cubicle and a nurse gives oxygen and Anginine, takes blood samples and conducts an ECG. The ECG is reviewed. At this point : **Emergency Department service event has commenced.**
- A doctor subsequently arrives and the patient is transferred to the catheter lab after examination.

Example 7

- The Emergency Department is notified by ambulance that a patient is being transported having severe behavioural problems.
- The patient is taken to an appropriate cubicle and restrained.
- A clinician administers sedation and requests the attendance of a mental health practitioner. At this point : **Emergency Department service event has commenced.**

Collection methods: Collected in conjunction with emergency department service commencement time.

Source and reference attributes

Submitting organisation: Australian Government Department of Health and Ageing

Relational attributes

Related metadata references: Supersedes Non-admitted patient emergency department service episode—service commencement date, DDMMYYYY Health, Superseded 22/12/2009

Implementation in Data Set Specifications: Non-admitted patient emergency department care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Emergency department departure date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Emergency department stay—physical departure date, DDMMYYYY
METeOR identifier:	322597
Registration status:	Health, Standard 24/03/2006
Definition:	The date on which a patient departs an emergency department after a stay.
Context:	Emergency department care.
Data Element Concept:	Emergency department stay—physical departure date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:

Each emergency department stay should include a non-admitted patient emergency department service episode component. The value of the episode end status code should guide the selection of the value to be recorded in this field:

- If the patient is subsequently admitted then record the date the patient leaves the Emergency Department to go to the admitted patient facility. Physically moving the patient to a bed in an emergency department specialist care unit (including EMU, short stay ward, emergency care unit or observation unit) is defined as representing departure from the emergency department.
- If the service episode is completed without the patient being admitted, including referral to another hospital, record the date the patient leaves the Emergency Department.
- If the patient did not wait record the date the patient leaves the Emergency Department or was first noticed as having left.
- If the patient left at their own risk record the date the patient leaves the Emergency Department.
- If the patient died in the Emergency Department record the date of death.
- If the patient was dead on arrival then record the date of presentation at the Emergency Department.

Collection methods: Collected in conjunction with emergency department stay physical departure time.

Comments: This data element has been developed for the purpose of State and Territory compliance with the Australian Health Care Agreement and the agreed national access performance indicator.

Source and reference attributes

Submitting organisation: Australian Government Department of Health and Ageing

Relational attributes

Implementation in Data Set Specifications:

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Non-admitted patient emergency department care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Emergency department departure time

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Emergency department stay—physical departure time, hhmm
METeOR identifier:	322610
Registration status:	Health, Standard 24/03/2006
Definition:	The time at which a patient departs an emergency department after a stay.
Context:	Emergency department care.
Data Element Concept:	Emergency department stay—physical departure time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Guide for use:

Each emergency department stay should include a non-admitted patient emergency department service episode component. The value of the episode end status code should guide the selection of the value to be recorded in this field:

- If the patient is subsequently admitted then record the time the patient leaves the Emergency Department to go to the admitted patient facility. Physically moving the patient to a bed in an emergency department specialist care unit (including EMU, short stay ward, emergency care unit or observation unit) is defined as representing departure from the emergency department.
- If the service episode is completed without the patient being admitted, including referral to another hospital, record the time the patient leaves the Emergency Department.
- If the patient did not wait record the time the patient leaves the Emergency Department or was first noticed as having left.
- If the patient left at their own risk record the time the patient leaves the Emergency Department.

- If the patient died in the Emergency Department record the time of death.
- If the patient was dead on arrival then record the time of presentation at the Emergency Department.

Collection methods: Collected in conjunction with emergency department stay physical departure date.

Comments: This data element has been developed for the purpose of State and Territory compliance with the Australian Health Care Agreement and the agreed national access performance indicator.

Source and reference attributes

Submitting organisation: Australian Government Department of Health and Ageing

Relational attributes

Implementation in Data Set Specifications:

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Non-admitted patient emergency department care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Emergency department episode end date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—episode end date, DDMMYYYY
METeOR identifier:	322616
Registration status:	Health, Standard 24/03/2006
Definition:	The date on which the non-admitted patient emergency department service episode ends.
Data Element Concept:	Non-admitted patient emergency department service episode—episode end date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:

A non-admitted patient emergency department service episode ends when either the patient is admitted or, if the patient is not to be admitted, when the patient is recorded as ready to leave the emergency department or when they are recorded as having left at their own risk.

For patients who subsequently undergo a formal admission an admitted patient episode of care should be recorded. The end of the non-admitted patient emergency department service episode should indicate the commencement of the admitted episode of care.

Source and reference attributes

Submitting organisation: Australian Government Department of Health and Ageing

Relational attributes

Implementation in Data Set Specifications:

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Non-admitted patient emergency department care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Emergency department episode end time

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—episode end time, hhmm
METeOR identifier:	322621
Registration status:	Health, Standard 24/03/2006
Definition:	The time at which the non-admitted patient emergency department service episode ends.
Data Element Concept:	Non-admitted patient emergency department service episode—episode end time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Guide for use:	A non-admitted patient emergency department service episode ends when either the patient is admitted or, if the patient is not to be admitted, when the patient is recorded as ready to leave the emergency department or when they are recorded as having left at their own risk. For patients who subsequently undergo a formal admission an admitted patient episode of care should be recorded. The end of the non-admitted patient emergency department service episode should indicate the commencement of the admitted episode of care.

Source and reference attributes

Submitting organisation:	Australian Government Department of Health and Ageing

Relational attributes

Implementation in Data Set Specifications:	Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Non-admitted patient emergency department care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Emergency department service episode end status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—episode end status, code N
METeOR identifier:	322641
Registration status:	Health, Standard 24/03/2006
Definition:	The status of the patient at the end of the non-admitted patient emergency department service episode, as represented by a code.
Data Element Concept:	Non-admitted patient emergency department service episode—episode end status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Admitted to this hospital (including to units or beds within the emergency department)
2	Non-admitted patient emergency department service episode completed - departed without being admitted or referred to another hospital
3	Non-admitted patient emergency department service episode completed - referred to another hospital for admission
4	Did not wait to be attended by a health care professional
5	Left at own risk after being attended by a health care professional but before the non-admitted patient emergency department service episode was completed
6	Died in emergency department as a non-admitted patient
7	Dead on arrival, not treated in emergency department

Collection and usage attributes

Guide for use:

CODE 2 Non-admitted patient emergency department service episode completed - departed without being admitted or referred to another hospital

This code includes patients who departed under their own care, under police custody, under the care of a residential aged care

facility or other carer. Code 2 excludes those who died in the emergency department, which should be coded to Code 6.

Source and reference attributes

Submitting organisation: Australian Government Department of Health and Ageing

Data element attributes

Collection and usage attributes

Guide for use: A non-admitted patient emergency department service episode ends when either the patient is admitted or, if the patient is not to be admitted, when the patient is recorded as ready to leave the emergency department or when they are recorded as having left at their own risk.

Collection methods: Some data systems may refer to this data element as 'Departure status'.

Source and reference attributes

Submitting organisation: Australian Government Department of Health and Ageing

Relational attributes

Related metadata references: Supersedes Non-admitted patient emergency department service episode—patient departure status, code N Health, Superseded 24/03/2006

Implementation in Data Set Specifications: Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Non-admitted patient emergency department care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Emergency department time of commencement of service event

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—service commencement time, hhmm
METeOR identifier:	390401
Registration status:	Health, Standard 22/12/2009
Definition:	The time at which a non-admitted emergency department service event commences.
Context:	Emergency Department care
Data Element Concept:	Non-admitted patient emergency department service episode—service commencement time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Guide for use:

An Emergency Department service event can be commenced by a doctor, nurse, mental health practitioner or other health professional, when investigation, care and/or treatment is provided in accordance with an established clinical pathway defined by the Emergency Department. Placement of a patient in a cubicle and observations taken to monitor a patient pending a clinical decision regarding commencement of a clinical pathway, do not constitute commencement.

The following examples illustrate the commencement of an Emergency Department service event.

Example 1

- A patient presents at the Emergency Department with mild asthma. At triage, the patient is categorised as category three and returns to the waiting area.
- The patient has a more severe asthma attack in the waiting

area, is re-triaged to category two and shown to a cubicle where standard observations are taken.

- A nurse comes to the cubicle and commences treatment based on an acknowledged clinical pathway of the Emergency Department. At this point : **Emergency Department service event has commenced.**

Example 2

- A patient presents at the Emergency Department in an agitated, delusional state. At triage, the patient is categorised as category two and placed in a cubicle and the mental health practitioner notified.
- Observations are taken and nursing staff continue to observe the patient.
- The mental health practitioner arrives, assesses the patient and develops a management plan. At this point : **Emergency Department service event has commenced.**

Example 3

- A patient presents at the Emergency Department with an ankle injury from football. At triage, the patient is categorised as category four and moved to the 'fast track area'.
- The physiotherapist attends, examines the patient, makes an assessment (including diagnostic imaging requirements) and determines a treatment plan. At this point : **Emergency Department service event has commenced.**

Example 4

- A patient presents at the Emergency Department with a sore arm, following a fall, with limited arm movement possible.
- The patient is categorised as category three at triage and placed in a cubicle.
- A nurse provides analgesia and assesses the patient, including ordering diagnostic imaging. At this point : **Emergency Department service event has commenced.**

Example 5

- A patient presents at the Emergency Department feeling vague and having been generally unwell for a day or two. The patient has a slight cough. At triage, the patient is categorised as category three.
- The patient is placed in a cubicle where standard observations are taken. Respiration is 26 bpm, BP is 90/60 and the patient is hypoxic. The patient is given oxygen, and the treating clinician attends and provides instruction regarding patient care. At this point : **Emergency Department service event has commenced.**

Example 6

- A patient presents at the Emergency Department with chest pain. Triage category two is allocated. The patient is placed in a cubicle and a nurse gives oxygen and Anginine, takes blood samples and conducts an ECG. The ECG is reviewed. At this point : **Emergency Department service event has commenced.**

- A doctor subsequently arrives and the patient is transferred to the catheter lab after examination.

Example 7

- The Emergency Department is notified by ambulance that a patient is being transported having severe behavioural problems.
- The patient is taken to an appropriate cubicle and restrained.
- A clinician administers sedation and requests the attendance of a mental health practitioner. At this point : **Emergency Department service event has commenced.**

Collection methods: Collected in conjunction with emergency department service episode service commencement date.

Source and reference attributes

Submitting organisation: Australian Government Department of Health and Ageing

Relational attributes

Related metadata references: Supersedes Non-admitted patient emergency department service episode—service commencement time, hhmm Health, Superseded 22/12/2009

Implementation in Data Set Specifications: Non-admitted patient emergency department care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Emergency department waiting time to admission

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—waiting time (to hospital admission), total hours and minutes NNNN
METeOR identifier:	270004
Registration status:	Health, Standard 01/03/2005
Definition:	The time elapsed for each patient from presentation to the emergency department to **admission** to hospital.
Data Element Concept:	Non-admitted patient emergency department service episode—waiting time (to hospital admission)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NNNN
Maximum character length:	4
Unit of measure:	Hour and minute

Collection and usage attributes

Guide for use:	HHMM

Data element attributes

Collection and usage attributes

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.
Comments:	This is a critical waiting times metadata item. It is used to examine the length of waiting time, for performance indicators and benchmarking. Information based on this metadata item will have many uses including to assist in the planning and management of hospitals and in health care research.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:

Is formed using Episode of admitted patient care—admission date, DDMMYYYY Health, Standard 01/03/2005

Is formed using Health service event—presentation time, hhmm Health, Standard 01/03/2005

Is formed using Non-admitted patient emergency department service episode—patient departure status, code N Health, Superseded 24/03/2006

Is formed using Episode of admitted patient care—admission time, hhmm Health, Standard 01/03/2005

Is formed using Health service event—presentation date, DDMMYYYY Health, Standard 01/03/2005

Supersedes Emergency department waiting time to admission, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.6 KB)

Emergency department waiting time to service delivery

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—waiting time (to service delivery), total minutes NNNNN
METeOR identifier:	390412
Registration status:	Health, Standard 22/12/2009
Definition:	The time elapsed in minutes for each patient from presentation in the emergency department to the commencement of the Emergency Department service event.
Data Element Concept:	Non-admitted patient emergency department service episode—waiting time

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NNNNN
Maximum character length:	5
Unit of measure:	Minute (m)

Data element attributes

Collection and usage attributes

Guide for use:	Calculated by subtracting date and time the patient presents from Emergency Department date and time of commencement of service event. Although triage category 1 is measured in seconds, it is recognised that the data will not be collected with this precision.
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.

Source and reference attributes

Submitting organisation:	National reference group for non-admitted patient data development, 2001-02

Relational attributes

Related metadata references:	Supersedes Non-admitted patient emergency department service episode—waiting time (to service delivery), total minutes NNNNN Health, Superseded 22/12/2009
Implementation in Data Set Specifications:	Non-admitted patient emergency department care NMDS 2010-2011 Health, Standard 22/12/2009 *Implementation start date:* 01/07/2010

Employee expenses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Organisation—employee related expenses, total Australian currency NNNNN.N
METeOR identifier:	359947
Registration status:	Health, Standard 05/12/2007
Definition:	Expenses of an organisation consisting mainly of wages, salaries and supplements, superannuation employer contributions, and workers compensation premiums and payouts, in Australian currency.
Data Element Concept:	Organisation—employee related expenses

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	NNNNN.N
Maximum character length:	6
Unit of measure:	Australian currency (AU$)

Source and reference attributes

Submitting organisation:	Health Expenditure Advisory Committee

Data element attributes

Collection and usage attributes

Guide for use:

Data are collected and nationally collated for the reporting period - the financial year ending 30th June each year.

Employee related expenses are to be reported in millions to the nearest 100,000 e.g. $4,064,000 should be reported as $4.1 million.

When revenue from transactions are offset against expenses from transactions, the result equates to the net operating balance in accordance with Australian Accounting Standards Board 1049 (September 2006).

Includes:

- Salaries, wages and supplements for all employees of the organisation (including contract staff employed by an agency, provided staffing 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.
- Superannuation employer 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, for a financial year.

- Workers compensation premiums and payments

Collection methods:

Employee related expenses are to be reported for the *Health industry relevant organisation type* and *Typeof health and health related functions* data elements.

Health industry relevant organisation type

State and territory health authorities are **NOT** to report the following codes:

Codes 106–109; 111; 115–119; 123; 201 and 203

Type of health and health related functions

State and territory health authorities are **NOT** to report the following codes:

Codes 199; 299; 303–305; 307; 499; 503–504; 599; 601–603; 688; 699

Comments:

In accounting terms, expenses are consumptions or losses of future economic benefits in the form of reductions in assets or increases in liabilities of the entity (other than those relating to distributions to owners) that result in a decrease in equity or net worth during the reporting period.

Source and reference attributes

Submitting organisation:

Health Expenditure Advisory Committee

Origin:

Australian Bureau of Statistics: Government Finance Statistics 1998, Cat. No. 5514.0.

Australian Bureau of Statistics 2006. Australian System of Government Finance Statistics: Concepts, sources and methods, 2005. Cat. no. 5514.0.55.001 Canberra: ABS.

Australian Accounting Standards Board 1049, September 2006, <www.aasb.com.au>

Relational attributes

Related metadata references:

Is used in the formation of Organisation—expenses, total Australian currency NNNNN.N Health, Standard 05/12/2007

Implementation in Data Set Specifications:

Government health expenditure organisation expenditure data cluster Health, Superseded 03/12/2008

Government health expenditure organisation expenditure data element cluster Health, Standard 01/04/2009

Government health expenditure organisation expenditure employee related data element cluster Health, Superseded 01/04/2009

Government health expenditure organisation expenditure employee related data element cluster Health, Standard 01/04/2009

Employment status (admitted patient)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—labour force status, acute hospital and private psychiatric hospital admission code N
METeOR identifier:	269948
Registration status:	Health, Standard 01/03/2005
Definition:	Self-reported employment status of a person, immediately prior to **admission** to an acute or private psychiatric hospital, as represented by a code.
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.
Data Element Concept:	Person—labour force status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Unemployed / pensioner
2	Other

Data element attributes

Collection and usage attributes

Collection methods:

In practice, this metadata 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

However, for national reporting purposes it is preferable to distinguish these two data items logically.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Employment status - acute hospital and private psychiatric hospital admissions, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)

Implementation in Data Set Specifications:

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Employment status—health professional

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—labour force status, registered health professional code N
METeOR identifier:	383389
Registration status:	Health, Standard 10/12/2009
Definition:	An indicator of whether a registered health professional is in paid employment, and if so whether the employment is within their registered profession.
Data Element Concept:	Registered health professional—labour force status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Employed in the registered profession
2	Employed outside the registered profession
3	Not employed

Supplementary values:

9	Unknown/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 EMPLOYED IN THE REGISTERED PROFESSION

Health professionals employed in the registered profession may be working in Australia or they may be working overseas.

CODE 2 EMPLOYED OUTSIDE OF THE REGISTERED PROFESSION

Health professionals who are employed in Australia or overseas, but not in the registered profession.

CODE 3 NOT EMPLOYED

Health professionals in this category may be unemployed (not employed and seeking work) or not in the labour force (not employed and not seeking work). This is consistent with the ABS Labour Force standard which allows the aggregation of 'Unemployed' and 'Not in the labour force' to form the category 'Not employed'.

FURTHER DEFINITIONS

The term 'employed' includes employees, employers, own account workers and contributing family workers.

The definitions of employed and unemployed in this data element differ slightly from Australian Bureau of Statistics (ABS) definitions. The main differences are:

- 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 during the week before registration.
- The scope of the labour force collection is all health professionals listed by the Australian Health Practitioner Regulation Agency, regardless of their residential status in Australia. The scope of the ABS Labour Force Survey is usual residents of Australia. That is, those persons who will be living in Australia for at least 12 months.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: Data is self-reported based on the health professional's status in the registered profession in the week before registration.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: Australian Bureau of Statistics 1996 Standards for Labour Force Statistics Cat.no. 1288.0 Canberra: ABS

Relational attributes

Related metadata references: Supersedes Health professional—labour force status, code N{.N}

Implementation in Data Set Specifications: Labour force status cluster Health, Standard 10/12/2009

Employment status—public psychiatric hospital admissions

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—labour force status, public psychiatric hospital admission code N
METeOR identifier:	269955
Registration status:	Health, Standard 01/03/2005
Definition:	Self-reported employment status of a person, immediately prior to **admission** to a public psychiatric hospital, as represented by a code.
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.
Data Element Concept:	Person—labour force status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

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

Data element attributes

Collection and usage attributes

Collection methods:	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

However, for national reporting purposes it is preferable to distinguish these two data items logically.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Employment status - public psychiatric hospital admissions, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.6 KB)

Implementation in Data Set Specifications:

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Environmental factor

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—environmental factor, code (ICF 2001) AN[NNN]
METeOR identifier:	320207
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The physical, social and attitudinal environment in which people live and conduct their lives, as represented by a code.
Context:	The environment in which a person functions or experiences disability.
Data Element Concept:	Person—environmental factor

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Functioning, Disability and Health 2001
Representation class:	Code
Data type:	String
Format:	AN[NNN]
Maximum character length:	5

Collection and usage attributes

Guide for use:

This metadata item contributes to the definition of the concept 'Disability' and gives an indication of the experience of disability for a person.

Environmental factors represent the circumstances in which the individual lives. These factors are conceived as immediate (e.g. physical features of the environment, social environment) and societal (formal and informal social structures, services and systems). Different environments may have a very different impact on the same individual with a given health condition.

Facilitators are features of the environment that have a positive effect on **disability**. Barriers are features of the environment that have a negative effect on disability.

Data can be collected at the three digit level in one chapter and at the chapter level in another. However it is only possible to collect data at a single level of the hierarchy in a single chapter to maintain mutual exclusivity. For example, it is not permitted to collect both 'Attitudes' (chapter level) and 'Social, norms, practices and ideology' (3 digit level) as the former includes the latter.

The value domain below refers to the highest hierarchical level (ICF chapter level). Data collected at this level, in association with *Extent of environmental factor influence code [X]N* will use the codes as indicated. The full range of the permissible values together

with definitions can be found in the *Environmental Factors* component of the ICF.

CODE e1 Products and technology
CODE e2 Natural environment and human-made changes to environment
CODE e3 Support and relationships
CODE e4 Attitudes
CODE e5 Services, systems and policies

Data collected at this level will provide a general description of the environmental factors and can only be compared with data collected at the same level.

An example of a value domain at the 3 digit level from the Environmental factors component may include:

CODE e225 Climate
CODE e240 Light
CODE e250 Sound
CODE e255 Vibration
CODE e260 Air quality

An example of a value domain at the 4 digit level from the environmental factors component may include:

CODE e1151 Assistive products and technology for personal use in daily life
CODE e1201 Assistive products and technology for personal indoor and outdoor mobility and transportation
CODE e2151 Assistive products and technology for communication
CODE e1301 Assistive products and technology for education
CODE e1351 Assistive products and technology for employment
CODE e1401 Assistive products and technology for culture, recreation and sport
CODE e1451 Assistive products and technology for the practice of religion and spirituality

The prefix ***e*** denotes the domains within the component of *Environmental Factors*.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin: WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents: Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website http://www.who.int/classifications/icf/en/
- Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.cfm

Data element attributes

Collection and usage attributes

Guide for use: This data element is a neutral list of environmental factors. It may be used, in conjunction with Person—extent of environmental factor influence, code (ICF 2001) [X]N, in health, community services and other disability-related data collections to record the environmental factors that facilitate or inhibit optimum functioning at the body, person or societal level. Identification of environmental factors may assist in determining appropriate interventions to support the person to achieve optimum functioning.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references: See also Person—extent of environmental factor influence, code (ICF 2001) [X]N Health, Standard 29/11/2006, Community services, Standard 16/10/2006

Implementation in Data Set Specifications: Environmental factors cluster Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Episode of residential care end date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of residential care—episode end date, DDMMYYYY
METeOR identifier:	270062
Registration status:	Health, Standard 01/03/2005
Definition:	Date on which a **resident** formally or statistically **ends an episode of residential care**.
Data Element Concept:	Episode of residential care—episode end date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Relational attributes

Related metadata references: Supersedes Episode of residential care end date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.6 KB)

Implementation in Data Set Specifications:

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Residential mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Residential mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Episode of residential care end mode

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of residential care—episode end mode, code N
METeOR identifier:	270063
Registration status:	Health, Standard 01/03/2005
Definition:	The reason for **ending an episode of residential care**, as represented by a code.
Data Element Concept:	Episode of residential care—episode end mode

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Died
2	Left against clinical advice / at own risk
3	Commenced leave where there is no intention that the resident returns to overnight residential care within seven days
4	Other end of residential care at this establishment
5	End of reference period

Supplementary values:

9	Unknown/not stated/inadequately described

Collection and usage attributes

Guide for use:

CODES 1 - 4 These codes refer to the formal episode of residential care end.

CODE 1 Died

CODE 2 Left against clinical advice / at own risk

CODE 3 Commenced leave where there is no intention that the resident returns to overnight residential care within seven days

CODE 5 End of reference period

This code refers to the statistical episode of residential care end.

CODE 9 Unknown/not stated/inadequately described

This code refers to other.

Data element attributes

Relational attributes

Related metadata references:

Supersedes Episode of residential care end mode, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.3 KB)

Implementation in Data Set Specifications:

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Residential mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Residential mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Episode of residential care start date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of residential care—episode start date, DDMMYYYY
METeOR identifier:	270064
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which the **resident** formally or statistically **starts an episode of residential care**.
Data Element Concept:	Episode of residential care—episode start date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Relational attributes

Related metadata references: Supersedes Episode of residential care start date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Implementation in Data Set Specifications:

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Residential mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Residential mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Episode of residential care start mode

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of residential care—episode start mode, code N
METeOR identifier:	270075
Registration status:	Health, Standard 01/03/2005
Definition:	The reason for starting an **episode of residential care**, as represented by a code.
Data Element Concept:	Episode of residential care—episode start mode

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Unplanned return from leave where there had been no intention that the resident would return to overnight residential care at the establishment within seven days
2	Other (i.e. start of a new residential stay)
3	Start of a new reference period

Supplementary values:

9	Unknown/not stated/inadequately described

Collection and usage attributes

Guide for use:

CODES 1-2 These codes refer to the formal episode of residential care start.

CODE 1 Unplanned return from leave where there had been no intention that the resident would return to overnight residential care at the establishment within seven days

CODE 2 Other (i.e. start of a new residential stay)

CODE 3 Start of a new reference period

This code refers to the statistical episode of residential care start.

CODE 9 Unknown/not stated/inadequately described

This code refers to other.

Data element attributes

Relational attributes

Related metadata references: Supersedes Episode of residential care start mode, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)

Implementation in Data Set Specifications:

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Residential mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Residential mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Erectile dysfunction

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (male)—erectile dysfunction, code N
METeOR identifier:	270132
Registration status:	Health, Standard 01/03/2005
Definition:	Whether a male individual has a history of erection failure or has received treatment to achieve erection sufficient for penetration in the last 12 months and prior, as represented by a code.
Data Element Concept:	Person (male)—erectile dysfunction

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Erectile dysfunction- developed in the last 12 months
	2	Erectile dysfunction- developed prior to the last 12 months
	3	No erectile dysfunction
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	Determine whether this developed within or prior to the last 12 months.
Collection methods:	Ask the individual if he has a history of treatment or failure to achieve or maintain erection sufficient for penetration.

Data element attributes

Collection and usage attributes

Guide for use:	Record for male patients only.

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:	Supersedes Erectile dysfunction, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Superseded 21/09/2005
	Diabetes (clinical) DSS Health, Standard 21/09/2005

Establishment identifier

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—organisation identifier (Australian), NNX[X]NNNNN
METeOR identifier:	269973
Registration status:	Health, Standard 01/03/2005
Definition:	The 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.
Data Element Concept:	Establishment—organisation identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	NNX[X]NNNNN
Maximum character length:	9

Data element attributes

Collection and usage attributes

Guide for use:	Concatenation of: Australian state/territory identifier (character position 1); Sector (character position 2); Region identifier (character positions 3-4); and Organisation identifier (state/territory), (character positions 5-9).
Comments:	Establishment identifier should be able to distinguish between all health care establishments nationally.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Establishment identifier, version 4, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.0 KB) Is formed using Establishment—Australian state/territory identifier, code N Health, Standard 01/03/2005 Is formed using Establishment—organisation identifier (state/territory), NNNNN Health, Standard 01/03/2005 Is formed using Establishment—sector, code N Health, Standard 01/03/2005

Is formed using Establishment—region identifier, X[X] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Admitted patient palliative care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient palliative care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient palliative care NMDS 2007-08 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient palliative care NMDS 2008-09 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient palliative care NMDS 2009-10 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient palliative care NMDS 2010-11 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Alcohol and other drug treatment services NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Community mental health care 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Community mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Community mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Community mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Community mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Community mental health establishments NMDS 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

Elective surgery waiting times (census data) NMDS Health, Superseded 07/12/2005

Implementation start date: 30/09/2002

Implementation end date: 30/06/2006

Elective surgery waiting times (census data) NMDS 2006-2009 Health, Superseded 03/12/2008

Implementation start date: 30/09/2006

Implementation end date: 31/03/2009

Elective surgery waiting times (census data) NMDS 2009- Health, Standard 03/12/2008

Implementation start date: 30/06/2009

Elective surgery waiting times (removals data) NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2002

Implementation end date: 30/06/2006

Elective surgery waiting times (removals data) NMDS 2006-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2006

Implementation end date: 30/06/2009

Elective surgery waiting times (removals data) NMDS 2009- Health, Standard 03/12/2008

Implementation start date: 01/07/2009

Health care client identification Health, Superseded 04/05/2005

Health care client identification DSS Health, Superseded 03/12/2008

Health care client identification DSS Health, Standard 03/12/2008

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Non-admitted patient emergency department care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Outpatient care NMDS Health, Superseded 04/07/2007

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Outpatient care NMDS Health, Standard 04/07/2007

Implementation start date: 01/07/2007

Perinatal NMDS Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Perinatal NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Perinatal NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Residential mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Residential mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Establishment number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—organisation identifier (state/territory), NNNNN
METeOR identifier:	269975
Registration status:	Health, Standard 01/03/2005
Definition:	An identifier for an establishment, unique within the state or territory.
Data Element Concept:	Establishment—organisation identifier (state/territory)

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	Number
Format:	NNNNN
Maximum character length:	5

Data element attributes

Collection and usage attributes

Comments:	Identifier should be a unique code for the health care establishment used in that state/territory.

Relational attributes

Related metadata references:	Supersedes Establishment number, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (14.6 KB) Is used in the formation of Establishment—organisation identifier (Australian), NNX[X]NNNNN Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Admitted patient care NMDS Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009 *Implementation start date:* 01/07/2008 *Implementation end date:* 30/06/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Superseded 06/03/2009

Cancer (clinical) DSS Health, Superseded 22/12/2009

Cancer (clinical) DSS Health, Standard 22/12/2009

Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Community mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Community mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Community mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Community mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Health care client identification Health, Superseded 04/05/2005

Health care client identification DSS Health, Superseded 03/12/2008

Health care client identification DSS Health, Standard 03/12/2008

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Residential mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Residential mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Establishment sector

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—sector, code N
METeOR identifier:	269977
Registration status:	Health, Standard 01/03/2005
Definition:	A section of the health care industry with which a health care establishment can identify, as represented by a code.
Data Element Concept:	Establishment—sector

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Public
2	Private

Data element attributes

Collection and usage attributes

Guide for use:

This data element is used to differentiate between establishments run by the government sector (code 1) and establishments that receive some government funding but are run by the non-government sector (code 2).

CODE 1 is to be used when the establishment:

- operates from the public accounts of a Commonwealth, state or territory government or is part of the executive, judicial or legislative arms of government,
- is part of the general government sector or is controlled by some part of the general government sector,
- provides government services free of charge or at nominal prices, and
- is financed mainly from taxation.

CODE 2 is to be used only when the establishment:

- is not controlled by government,
- is directed by a group of officers, an executive committee or a similar body
- elected by a majority of members, and
- may be an income tax exempt charity.

Relational attributes

Related metadata references:

Supersedes Establishment sector, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.8 KB)

Is used in the formation of Establishment—organisation identifier (Australian), NNX[X]NNNNN Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Community mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Community mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Community mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Community mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Health care client identification Health, Superseded 04/05/2005

Health care client identification DSS Health, Superseded 03/12/2008

Health care client identification DSS Health, Standard 03/12/2008

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Residential mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Residential mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Establishment type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—establishment type, sector and services provided code AN.N{.N}
METeOR identifier:	269971
Registration status:	Health, Standard 01/03/2005
Definition:	Type of establishment (defined in terms of legislative approval, service provided and patients treated) for each separately administered establishment, as represented by a code.
Data Element Concept:	Establishment—establishment type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	AN.N{.N}
Maximum character length:	6

Permissible values:

Value	Meaning
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
R2.1	Public psychiatric hospital
R2.2	Private psychiatric hospital
R3.1	Private charitable nursing home for the aged
R3.2	Private profit nursing home for the aged
R3.3	Government nursing home for the aged
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
R5.2	State government hostel for the aged
R4.1	Public alcohol and drug treatment centre
R4.2	Private alcohol and drug treatment centre
R5.1	Charitable hostels 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
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

Collection and usage attributes

Guide for use:

Establishments are classified into 10 major types subdivided into major groups:

- residential establishments (R)
- non-residential establishments (N)

CODE R1 Acute care hospitals

Establishments which provide at least minimal medical, surgical or obstetric services for inpatient 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.

CODE R2 Psychiatric hospitals

Establishments devoted primarily to the treatment and care of inpatients 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.

CODE R3 Nursing homes

Establishments which provide long-term care involving regular basic nursing care to chronically ill, frail, disabled or convalescent

persons or senile inpatients. 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 nursing homes are operated by private profit-making individuals or bodies.

Private charitable nursing homes are participating nursing homes operated by religious and charitable organisations.

Government nursing homes are nursing homes either operated by or on behalf of a state or territory Government.

CODE R4 Alcohol and drug treatment centres

Freestanding centres for the treatment of drug dependence on an inpatient basis.

CODE 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 nursing home. 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.

CODE 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.

CODE N7 Same-day establishments

This code 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.

CODE 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.

CODE 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.

CODE 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.

Comments: Note that national minimum data sets currently include only community health centres and domiciliary nursing services.

Data element attributes

Collection and usage attributes

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 metadata item is currently under review by the Establishments Framework Working Group of the Health Data Standards Committee. Recommendations will provide a comprehensive coverage of the health service delivery sector.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Establishment type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (31.2 KB)

Is used in the formation of Episode of care—number of psychiatric care days, total N[NNNN] Health, Standard 01/03/2005

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Extended leave status in registered profession

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—extended leave status in registered profession, code N
METeOR identifier:	383415
Registration status:	Health, Standard 10/12/2009
Definition:	Whether a registered health professional is on extended leave (3 months or more) from their registered profession, as represented by a code.
Data Element Concept:	Registered health professional—extended leave status in registered profession

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	On extended leave (3 months or more)
2	Not on extended leave

Supplementary values:

9	Unknown/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 ON EXTENDED LEAVE (3 MONTHS OR MORE)

The person is on a period of leave from their place of employment for three months or more. The person may be starting their extended leave or they may be part-way through their extended leave.

CODE 2 NOT ON EXTENDED LEAVE

The person is not on a period of leave for three months or more. They may be working or they may be on short-term leave of less than three months.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	This data element is applicable to registered health professionals who are employed in the registered profession.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Labour force status cluster Health, Standard 10/12/2009

Extended wait patient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—extended wait patient indicator, code N
METeOR identifier:	269964
Registration status:	Health, Standard 01/03/2005
Definition:	Whether a patient is an extended wait patient, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode—extended wait patient indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Extended wait patient
2	Other patient

Data element attributes

Collection and usage attributes

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.
Comments:	This metadata 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.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Extended wait patient, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.8 KB)
	Is formed using Elective surgery waiting list episode—waiting

time (at a census date), total days N[NNN] Health, Standard 01/03/2005

Is formed using Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Elective surgery waiting times (census data) NMDS Health, Superseded 07/12/2005

Implementation start date: 30/09/2002

Implementation end date: 30/06/2006

Elective surgery waiting times (census data) NMDS 2006-2009 Health, Superseded 03/12/2008

Implementation start date: 30/09/2006

Implementation end date: 31/03/2009

Elective surgery waiting times (census data) NMDS 2009- Health, Standard 03/12/2008

Implementation start date: 30/06/2009

Elective surgery waiting times (removals data) NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2002

Implementation end date: 30/06/2006

Elective surgery waiting times (removals data) NMDS 2006-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2006

Implementation end date: 30/06/2009

Elective surgery waiting times (removals data) NMDS 2009- Health, Standard 03/12/2008

Implementation start date: 01/07/2009

Extent of participation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—extent of participation in a life area, code (ICF 2001) N
METeOR identifier:	320219
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The degree of participation by an individual in a specified life area, as represented by a code.
Context:	Human functioning and disability
Data Element Concept:	Person—extent of participation in a life area

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Functioning, Disability and Health 2001
Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
0	Full participation
1	Mild participation restriction
2	Moderate participation restriction
3	Severe participation restriction
4	Complete participation restriction

Supplementary values:

Value	Meaning
8	Not specified
9	Not applicable

Collection and usage attributes

Guide for use:

This metadata item contributes to the definition of the concept '**Disability**' and gives an indication of the experience of disability for a person.

In the context of health, participation is involvement in a life situation. Participation restrictions are problems an individual may experience in involvement of life situations.

This metadata item may be used to describe the extent of **participation** in life situations for an individual with a health condition. The standard or norm to which an individual's participation is compared is that of an individual without a similar health condition in that particular society. The participation restriction records the discordance between the experienced participation and the expected participation of an

individual without a health condition. The definition of 'particular society' is not specified and will inevitably give rise to different interpretations. If limiting the interpretation, it will be necessary to state the factors which are taken into account, for example, age, gender, ethnicity, religion, education, locality (town, state, rural, remote, urban).

The user will select the code that most closely summarises, in terms of duration, frequency, manner or outcome, the level of participation of the person for whom the data is recorded.

CODE 0 Full participation

Used when the person participates in this life area in the same way in terms of duration, frequency, manner or outcome as other individuals without a similar health condition in that particular society

CODE 1 Mild participation restriction

Used for example, when the person is restricted in their participation less than 25% of the time, and/or with a low alteration in functioning which may happen occasionally over the last 30 days

CODE 2 Moderate participation restriction

Used for example, when the person is restricted in their participation between 26% and 50% of the time with a significant, and/or with a moderate effect on functioning (Up to half the total scale of performance) which may happen regularly over the last 30 days

CODE 3 Severe participation restriction

Used for example, when participation in this life area can be achieved, but only rarely and/or with an extreme effect on functioning which may happen often over the last 30 days

CODE 4 Complete participation restriction

Used when the person can not participate in this life area. This scale has a margin of error of 5%

CODE 8 Not specified

Used when a person's participation in a life area is restricted but there is insufficient information to use codes 0-4

CODE 9 Not applicable

Used when participation in a life area is not relevant, such as employment for an infant.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin: WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents:

Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website http://www.who.int/classifications/icf/en/
- Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.cfm

Data element attributes

Collection and usage attributes

Guide for use:

Extent of participation is always associated with a health condition. For example, a restriction in participation in 'community, social and civic life' may be recorded when the person has had a stroke, but not when the restriction is associated only with personal preferences, without a related health condition. A value is attached to restriction of participation (i.e. a participation restriction is a disadvantage). The value is dependent on cultural norms, so that an individual may be disadvantaged in one group or location and not in another place.

This data element is used in conjunction with a specified Activities and participation life area (ICF 2001) AN[NNN]. For example, a 'mild restriction in participation in exchange of information'.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references:

See also Person—activity and participation life area, code (ICF 2001) AN[NNN] Health, Standard 29/11/2006, Community services, Standard 16/10/2006

Implementation in Data Set Specifications:

Activities and Participation cluster Health, Standard 29/11/2006 Community services, Standard 16/10/2006

External cause

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—external cause, code (ICD-10-AM 7th edn) ANN{.N[N]}
METeOR identifier:	391330
Registration status:	Health, Standard 22/12/2009
Definition:	The environmental event, circumstance or condition as the cause of injury, poisoning and other adverse effect, as represented by a code.
Data Element Concept:	Injury event—external cause

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:	This code must be used in conjunction with an injury or poisoning code and can be used with other disease codes. The external cause should be coded to the complete ICD-10-AM 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 V00 to Y84 must be accompanied by a place of occurrence code. External cause codes V00 to Y34 must be accompanied by an activity code.
Comments:	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. An extended activity code is being developed in consultation with the National Injury Surveillance Unit, Flinders University, Adelaide.

Source and reference attributes

Origin: National Centre for Classification in Health

National Data Standards for Injury Surveillance Advisory Group

Relational attributes

Related metadata references: Supersedes Injury event—external cause, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009

Implementation in Data Set Specifications: Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Injury surveillance DSS Health, Standard 14/12/2009

External cause (non-admitted patient)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—external cause, non-admitted patient code NN
METeOR identifier:	269988
Registration status:	Health, Standard 01/03/2005
Definition:	Environmental event, circumstance or condition as the cause of injury, poisoning or other adverse effect to a non-admitted patient.
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.
Data Element Concept:	Injury event—external cause

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
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
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)
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 and Dog)
23	(deleted)
24	Machinery in operation
25	Electricity
26	Hot conditions (natural origin) sunlight
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

Collection and usage attributes

Comments: This code list has been derived from the ICD-10-AM external cause classification.

Source and reference attributes

Reference documents: International Classification of Diseases - Tenth Revision - Australian Modification (3rd edition 2002)

Data element attributes

Collection and usage attributes

Guide for use: This metadata item 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). 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 metadata item Injury event—external cause, non-admitted patient human intent code NN).

Comments: This metadata item has been developed to cater for the information requirements of the wide range of settings where injury surveillance is undertaken and do not have the capability of recording the complete ICD-10-AM external cause codes.

Further information on the national injury surveillance program can be obtained from the National Injury Surveillance Unit, Flinders University, Adelaide.

Source and reference attributes

Origin: National Centre for Classification in Health

National Data Standards for Injury Surveillance Advisory Group

National Health Data Committee

Reference documents: International Classification of Diseases - Tenth Revision - Australian Modification (3rd Edition 2002) National Centre for Classification in Health, Sydney

Relational attributes

Related metadata references: Supersedes External cause - non-admitted patient, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.0 KB)

External cause—human intent

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—human intent of injury, code NN
METeOR identifier:	268944
Registration status:	Health, Standard 01/03/2005
Definition:	The clinician's assessment identifying the most likely role of human intent in the occurrence of the injury or poisoning, as represented by a code.
Data Element Concept:	Injury event—human intent of injury

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
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

Collection and usage attributes

Guide for use:

Select the code 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 metadata item must always be accompanied by an Injury event—external cause, non-admitted patient human intent code NN code.

This Value 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).

Data element attributes

Collection and usage attributes

Comments: 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.

Source and reference attributes

Submitting organisation: National Data Standards for Injury Surveillance Advisory Group

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes External cause - human intent, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.4 KB)

Implementation in Data Set Specifications:

Injury surveillance DSS Health, Superseded 05/02/2008

Injury surveillance DSS Health, Superseded 14/12/2009

Injury surveillance DSS Health, Standard 14/12/2009

Injury surveillance NMDS Health, Superseded 03/05/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Injury surveillance NMDS Health, Superseded 07/12/2005

Family name

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (name)—family name, text X[X(39)]
Synonymous names:	Surname; Last name
METeOR identifier:	286953
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 20/06/2005
Definition:	That part of a name a person usually has in common with some other members of his/her family, as distinguished from his/her given names, as represented by text.
Data Element Concept:	Person (name)—family name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	X[X(39)]
Maximum character length:	40

Data element attributes

Collection and usage attributes

Guide for use:	The agency or establishment should record the person's full **family** name on their information systems. National Community Services Data Dictionary specific: In instances where there is uncertainty about which name to record for a person living in a remote Aboriginal or Torres Strait Islander community, Centrelink follows the practice of recording the Indigenous person's name as it is first provided to Centrelink. Or, where proof of identity is required, as the name that is recorded on a majority of the higher point scoring documents that are produced as proof of identity.
Collection methods:	This metadata item should be recorded for all persons who receive services from or are of interest to an organisation. For the purposes of positive identification, it may also be recorded for providers of those services who are individuals. Mixed case should be used. Family name should be recorded in the format preferred by the person. The format should be the same as that written by the person on a (pre) registration form or in the same format as that printed on an identification card, such as a Medicare card, to ensure consistent collection of name data.

It is acknowledged that some people use more than one family name (e.g. formal name, birth name, married/maiden name, tribal name) depending on the circumstances. Each name should be recorded against the appropriate Name type (see Comments).

A person is able to change his or her name by usage in all States and Territories of Australia with the exception of Western Australia, where a person may only change his or her name under the Change of Name Act. Care should be taken when recording a change of name for a minor. Ideally, the name recorded for the minor should be known to both of his/her parents, so the minor's records can be retrieved and continuity of care maintained, regardless of which parent accompanies the minor to the agency or establishment.

A person should generally be registered using their preferred name as it is more likely to be used in common usage and on subsequent visits to the agency or establishment. The person's preferred name may in fact be the name on their Medicare card. The Person name type metadata item can be used to distinguish between the different types of names that may be used by the person. The following format may assist with data collection:

What is your family name?

_____

Are you known by any other family names that you would like recorded? If so, what are they

_____

Please indicate, for each name above, the 'type' of family name that is to be recorded:

(a) Medicare card name (if different to preferred name).

(b) Alias (any other name that you are known by). Whenever a person informs the agency or establishment of a change of family name (e.g. following marriage or divorce), the former name should be recorded as an alias name. A full history of names should be retained. e.g. 'Mary Georgina Smith' informs the hospital that she has been married and changed her family name to 'Jones'. Record 'Jones' as her preferred family name and record 'Smith' as an alias name.

Hyphenated family names:

Sometimes persons with hyphenated family names use only one of the two hyphenated names. It is useful to record each of the hyphenated names as an alias. If the person has a hyphenated family name, e.g. 'Wilson-Phillips' record 'Wilson-Phillips' in the preferred family name field and record 'Wilson' and 'Phillips' separately as alias family names.

Punctuation:

If special characters form part of the family name they should be included, e.g. hyphenated names should be entered with a hyphen.

Examples:

- hyphen, e.g. Wilson-Phillips

Do not leave a space before or after a hyphen, i.e. between the

last letter of 'Wilson' and the hyphen, nor a space between the hyphen and the first letter of 'Phillips'.

- apostrophe, e.g. O'Brien, D'Agostino

Do not leave a space before or after the apostrophe, i.e. between the 'O' and the apostrophe, or a space between the apostrophe and 'Brien'.

- full stop, e.g. St. John, St. George

Do not leave a space before a full stop, i.e. between 'St' and the full stop. Do leave a space between the full stop and 'John'.

- space, e.g. van der Humm, Le Brun, Mc Donald

If the health care client has recorded their family name as more than one word, displaying spaces in between the words, record their family name in the same way leaving one space between each word.

Registered unnamed newborn babies:

When registering a newborn, use the mother's family name as the baby's family name unless instructed otherwise by the mother. Record unnamed babies under the newborn Name type.

Persons with only one name:

Some people do not have a family name and a given name, they have only one name by which they are known. If the person has only one name, record it in the 'Family name' field and leave the 'Given name' field blank.

Registering an unidentified person:

The default for unknown family name should be unknown in all instances and the name recorded as an alias name. Don't create a 'fictitious' family name such as 'Doe' as this is an actual family name. When the person's name becomes known, record it as the preferred family name and do not overwrite the alias name of unknown.

Registering health care clients from disaster sites:

Persons treated from disaster sites should be recorded under the alias Name Type. Local business rules should be developed for consistent recording of disaster site person details.

Care should be taken not to use identical dummy data (family name, given name, date of birth, sex) for two or more persons from a disaster site.

If the family name needs to be shortened:

If the length of the family name exceeds the length of the field, truncate the family name from the right (that is, dropping the final letters). Also, the last character of the name should be a hash (#) to identify that the name has been truncated.

Use of incomplete names or fictitious names:

Some health care facilities permit persons to use a pseudonym (fictitious or partial name) in lieu of their full or actual name. It is recommended that the person be asked to record both the pseudonym (Alias name) in addition to the person's Medicare card name.

Baby for **adoption**:

The word adoption should not be used as the family name, given name or alias for a newborn baby. A newborn baby that is for adoption should be registered in the same way that other newborn babies are registered. However, if a baby born in the hospital is subsequently adopted, and is admitted for treatment as a child, the baby is registered under their adopted (current) name, and the record should not be linked to the birth record. This should be the current practice. Any old references to adoption in client registers (for names) should also be changed to unknown. Contact your State or Territory adoption information service for further information.

Prefixes:

Where a family name contains a prefix, such as one to indicate that the person is a widow, this must be entered as part of the 'Family name' field. When widowed, some Hungarian women add 'Ozvegy' (abbreviation is 'Ozy') before their married family name, e.g. 'Mrs Szabo' would become 'Mrs Ozy Szabo'. That is, 'Mrs Szabo' becomes an alias name and 'Mrs Ozy Szabo' becomes the preferred name.

Ethnic Names:

The Centrelink publication, Naming Systems for Ethnic Groups, provides the correct coding for ethnic names.

Misspelled family name:

If the person's family name has been misspelled in error, update the family name with the correct spelling and record the misspelled family name as an alias name. Recording misspelled names is important for filing documents that may be issued with previous versions of the person's name. Discretion should be used regarding the degree of recording that is maintained.

Comments:

Often people use a variety of names, including legal names, married/maiden names, nicknames, assumed names, traditional names, etc. Even small differences in recording - such as the difference between MacIntosh and McIntosh - can make record linkage impossible. To minimise discrepancies in the recording and reporting of name information, agencies or establishments should ask the person for their full (formal) 'Given name' and 'Family name'. These may be different from the name that the person may prefer the agency or establishment workers to use in personal dealings. Agencies or establishments may choose to separately record the preferred names that the person wishes to be used by agency or establishment workers. In some cultures it is traditional to state the family name first. To overcome discrepancies in recording/reporting that may arise as a result of this practice, agencies or establishments should always ask the person to specify their first given name and their family name or surname separately. These should then be recorded as 'Given name' and 'Family name' as appropriate, regardless of the order in which they may be traditionally given.

National Community Services Data Dictionary specific:

Selected letters of the family name in combination with selected

letters of the given name, date of birth and sex, may be used for record linkage for statistical purposes only.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Standards Australia

Origin: National Health Data Committee

National Community Services Data Committee

Commonwealth Department of Health and Family Services 1998. Home and Community Care Data Dictionary Version 1.0. Canberra: DHFS Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Reference documents: AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references: See also Person (name)—given name, text [X(40)] Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 20/06/2005

Supersedes Person (name)—family name, text X[X(39)] Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005

Is used in the formation of Person (name)—letters of name, text XXXXX Community services, Standard 14/09/2009

Is used in the formation of Person—letters of given name, text XX Community services, Standard 27/03/2007

Is used in the formation of Person—letters of family name, text XXX Community services, Standard 27/03/2007

Implementation in Data Set Specifications: Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Superseded 06/03/2009

Cancer (clinical) DSS Health, Superseded 22/12/2009

Cancer (clinical) DSS Health, Standard 22/12/2009

Health care client identification DSS Health, Superseded 03/12/2008

Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Superseded 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Fasting status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health service event—fasting indicator, code N
METeOR identifier:	302941
Registration status:	Health, Standard 21/09/2005
Definition:	Whether the patient was fasting at the time of an examination, test, investigation or procedure, as represented by a code.
Data Element Concept:	Health service event—fasting indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described
	This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes: Record if the patient is fasting at the time of an examination, test, investigation or procedure.
	CODE 2 No: Record if the patient is not fasting at the time of an examination, test, investigation or procedure.
Comments:	In settings where the monitoring of a person's health is ongoing and where management can change over time (such as general practice), the service contact date should be recorded.

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group
	Cardiovascular Data Working Group

Relational attributes

Related metadata references:

Supersedes Health service event—fasting status, code N Health, Superseded 21/09/2005

Is used in the formation of Person—low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N Health, Standard 01/10/2008

Is used in the formation of Person—low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N Health, Superseded 01/10/2008

Implementation in Data Set Specifications:

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Diabetes (clinical) DSS Health, Standard 21/09/2005

Feedback collection indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—feedback collection indicator, yes/no code N
METeOR identifier:	290438
Registration status:	Health, Standard 05/12/2007
Definition:	Whether feedback relating to services and service delivery is actively and routinely collected from clients and staff within a service provider organisation, as represented by a code.
Data Element Concept:	Service provider organisation—feedback collection indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

The active and routine collection of feedback from clients and/or staff means that, as a matter of routine, the agency initiates and implements feedback mechanisms and does not rely on mechanisms such as ad hoc comments, ad hoc questionnaires, informal debriefing sessions, or similar casual arrangements.

Active mechanisms include the use of periodic questionnaires that are implemented through either face-to-face interviews, by telephone or by mail, focus groups aimed at collecting feedback from the participants, established debriefing sessions, or other routine procedures the agency has in place to collect feedback.

CODE 1 Yes

The service provider organisation actively and routinely collects feedback relating to services and service delivery from clients and staff within the service provider organisation. If feedback is actively and routinely collected from clients only or staff only, this should be recorded as 'No' (Code 2).

CODE 2 No

The service provider organisation does not actively and routinely

	collect feedback relating to services and service delivery from clients and staff within the service provider organisation.
Collection methods:	Record only one code.

Source and reference attributes

Submitting organisation:	Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications:	Palliative care performance indicators DSS Health, Standard 05/12/2007

Feedback collection method

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—feedback collection method, code N
METeOR identifier:	290476
Registration status:	Health, Standard 05/12/2007
Definition:	The method the service provider organisation employs to actively and routinely collect feedback on services and service delivery, as represented by a code.
Data Element Concept:	Service provider organisation—feedback collection method

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Questionnaire - periodic face-to-face interview
2	Questionnaire - face-to-face interview on exit
3	Questionnaire - periodic telephone interview
4	Questionnaire - telephone interview on exit
5	Questionnaire - periodic written survey
6	Questionnaire - written survey on exit
7	Feedback focus group
8	Other

Data element attributes

Collection and usage attributes

Guide for use:

The active and routine collection of feedback means that, as a matter of routine, the agency initiates and implements feedback methods and does not rely on mechanisms such as ad hoc comments, ad hoc questionnaires, informal debriefing sessions, or similar casual arrangements.

Active methods include the use of periodic questionnaires that are implemented through either face-to-face interviews, by telephone or by mail, focus groups aimed at collecting feedback from the participants, established debriefing sessions, or other routine procedures the agency has in place to collect feedback.

The aim of the method used must be to collect feedback on services and service delivery.

'Periodic' may mean at set intervals or at (a) specified points in time during the service episode.

'On exit' refers to the closure of the service episode (for clients or related people), or (for staff) the time at which the staff member ceases to be employed by the agency.

CODE 7 Feedback focus group

An in-depth qualitative interview with a small number of persons, held specifically to collect feedback from the participants.

Collection methods: More than one code can be recorded.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications: Palliative care performance indicators DSS Health, Standard 05/12/2007

Conditional obligation:
Recorded when the data element *Service provider organisation – feedback collection indicator, yes/no code N* value is 'yes' (code 1).

Fibrinolytic drug used

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—fibrinolytic drug administered, code N
METeOR identifier:	356870
Registration status:	Health, Standard 01/10/2008
Definition:	The type of fibrinolytic drug administered to a person, as represented by a code.
Data Element Concept:	Person—fibrinolytic drug administered

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Streptokinase
2	t-PA (Tissue Plasminogen Activator) (Alteplase)
3	r-PA (Reteplase)
4	TNK t-PA (Tenecteplase)

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group

Relational attributes

Related metadata references:	Supersedes Person—fibrinolytic drug administered, code N Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008

Conditional obligation:
If prescribed, provide the fibrinolytic drug administered.

Fibrinolytic therapy status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—fibrinolytic therapy status, code NN
METeOR identifier:	285087
Registration status:	Health, Standard 04/06/2004
Definition:	The person's fibrinolytic therapy status, as represented by a code.
Data Element Concept:	Person—fibrinolytic therapy status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
10	Given
21	Not given - therapy not indicated
22	Not given - patient refusal
23	Not given - previous haemorrhagic stroke at any time; other strokes or cerebrovascular events within 1 year
24	Not given - known intracranial neoplasm
25	Not given - active or recent (within 2 to 4 weeks) internal bleeding (does not include menses)
26	Not given - suspected aortic dissection
27	Not given - severe uncontrolled hypertension on presentation (blood pressure >180 mmHg systolic and/or 110 mmHg diastolic). Note: This could be an absolute contraindication in low-risk patients with MI.
28	Not given - history of prior cerebrovascular accident or known intracerebral pathology not covered in 2.3 & 2.4 contraindications
29	Not given - current use of anticoagulants in therapeutic doses (INR greater than or equal to 2); known bleeding diathesis
30	Not given - recent trauma (within 2 to 4 weeks), including head trauma, traumatic or prolonged (greater than 10 minutes) CPR, or major surgery (less than 3 weeks)
31	Not given - pregnancy
32	Not given - other

Supplementary values:	90	Not stated/inadequately described

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: CODES 23, 24, 25, 26, 27, 28, 29, 30 and 31

More than one code may be recorded for the following codes: 23, 24, 25, 26, 27, 28, 29, 30 and 31.

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Steward: The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references: Supersedes Fibrinolytic therapy status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.0 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Field of medicine—medical practitioner

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—principal field of medicine, medical practitioner code N
METeOR identifier:	377809
Registration status:	Health, Standard 10/12/2009
Definition:	The field of medicine in which a medical practitioner spent the most hours in the week before registration, as represented by a code.
Data Element Concept:	Registered health professional—principal field of medicine

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	General practitioner (GP)
2	Hospital non-specialist (salaried)
3	Specialist
4	Specialist-in-training
5	Other clinician
6	Non-clinician

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 GENERAL PRACTITIONER

A medical practitioner who works in general practice and has membership with the Royal Australian College of General Practice (RACGP) or who holds a training position supervised by a member of the college. It includes medical practitioners who are currently:

- Vocationally registered
- a RACGP fellow
- a RACGP fellowship trainee
- a GP registrar

CODE 2 HOSPITAL NON-SPECIALIST (SALARIED)

A medical practitioner mainly employed in a salaried position in a hospital who is not in training to gain a recognised specialist qualification. They include interns, Resident Medical Officers

(RMOs), and Hospital Medical Officers (HMOs).

CODE 3 SPECIALIST

A medical practitioner with a qualification awarded by, or which equates to that awarded by, the relevant specialist professional college in Australia and works in that speciality area.

CODE 4 SPECIALIST-IN-TRAINING

A medical practitioner who has been accepted by a specialist medical college into a training position supervised by a member of the college and is working in that position.

CODE 5 OTHER CLINICIAN

A medical practitioner that has mainly undertaken clinical work in the week before registration, but who does not fall into any of the above categories.

CODE 6 NON-CLINICIAN

Includes all medical practitioners that have not mainly undertaken clinical work in the week prior to registration.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Registered medical professional labour force DSS Health, Standard 10/12/2009

First day of the last menstrual period

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Pregnancy—first day of the last menstrual period, date DDMMYYYY
METeOR identifier:	270038
Registration status:	Health, Standard 01/03/2005
Definition:	Date of the first day of the mother's last menstrual period (LMP).
Data Element Concept:	Pregnancy—first day of the last menstrual period

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	If the first day is unknown, it is unnecessary to record the month and year (i.e. record 99999999).
Comments:	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.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes First day of the last menstrual period, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.6 KB) Is used in the formation of Female (pregnant)—estimated gestational age, total weeks NN Health, Superseded 02/12/2009

Floor/level number (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—floor/level identifier, [NNNA]
Synonymous names:	Australian level number
METeOR identifier:	270029
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	The unique identifier for the floor/level where a person can be located.
Data Element Concept:	Person (address)—floor/level identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	[NNNA]
Maximum character length:	4

Data element attributes

Collection and usage attributes

Guide for use:	Floor/level number and suffix are both optional. The Floor/level number must be recorded with its corresponding Floor/level type. Some Floor/level numbers may be followed by an alphabetic suffix. Examples of Floor/level identification: FL 1A L 3 LG A
Collection methods:	Do not leave a space between the number and alpha suffix. To be collected in conjunction with Floor/level type.

Source and reference attributes

Origin:	Health Data Standards Committee Australia Post Address Presentation Standard
Reference documents:	AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

Related metadata references:	Supersedes Floor/level number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)
	Is used in the formation of Person (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005
	Is used in the formation of Person (address)—health address line, text [X(180)] Health, Superseded 04/05/2005
Implementation in Data Set Specifications:	Health care client identification DSS Health, Superseded 03/12/2008
	Health care client identification DSS Health, Standard 03/12/2008
	Health care provider identification DSS Health, Superseded 04/07/2007
	Health care provider identification DSS Health, Superseded 03/12/2008
	Health care provider identification DSS Health, Standard 03/12/2008

Floor/level number (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—floor/level identifier, [NNNA]
METeOR identifier:	290264
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The unique identifier for floor/level, where an organisation can be located.
Data Element Concept:	Service provider organisation (address)—floor/level identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	[NNNA]
Maximum character length:	4

Data element attributes

Collection and usage attributes

Guide for use:	Floor/level number and suffix are both optional. The Floor/level number must be recorded with its corresponding Floor/level type. Some Floor/level numbers may be followed by an alphabetic suffix. Examples of Floor/level identification: FL 1A L 3 LG A
Collection methods:	Do not leave a space between the number and alpha suffix. To be collected in conjunction with Floor/level type.

Source and reference attributes

Origin:	Health Data Standards Committee Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Is used in the formation of Service provider organisation (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007
	Health care provider identification DSS Health, Superseded 03/12/2008
	Health care provider identification DSS Health, Standard 03/12/2008

Floor/level type (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—floor/level type, code A[A]
Synonymous names:	Australian level type
METeOR identifier:	270024
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	The type of floor/level where a person can be located, as represented by a code.
Data Element Concept:	Person (address)—floor/level type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A[A]
Maximum character length:	2

Permissible values:

Value	Meaning
B	Basement
FL	Floor
G	Ground
L	Level
LG	Lower Ground
M	Mezzanine
UG	Upper Ground

Data element attributes

Collection and usage attributes

Guide for use:	Some floor/level identification may require the Floor/level type plus a Floor/level number to be recorded.
Collection methods:	To be collected in conjunction with Floor/level number where applicable. Some Floor/level type entries will often have no corresponding number e.g. Basement, Ground, Lower ground, Mezzanine and Upper ground.

Source and reference attributes

Origin:	Health Data Standards Committee Australia Post Address Presentation Standard
Reference documents:	AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

Related metadata references:

Supersedes Floor/level type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.5 KB)

Is used in the formation of Person (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is used in the formation of Person (address)—health address line, text [X(180)] Health, Superseded 04/05/2005

Implementation in Data Set Specifications:

Health care client identification DSS Health, Superseded 03/12/2008

Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Superseded 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Floor/level type (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—floor/level type, code A[A]
METeOR identifier:	290245
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The type of floor/level where an organisation can be located, as represented by a code.
Data Element Concept:	Service provider organisation (address)—floor/level type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A[A]
Maximum character length:	2

Permissible values:

Value	Meaning
B	Basement
FL	Floor
G	Ground
L	Level
LG	Lower Ground
M	Mezzanine
UG	Upper Ground

Data element attributes

Collection and usage attributes

Collection methods:	To be collected in conjunction with Floor/level number where applicable. Some Floor/level type entries will often have no corresponding number e.g. Basement, Ground, Lower ground, Mezzanine and Upper ground.

Source and reference attributes

Origin:	Health Data Standards Committee Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Is used in the formation of Service provider organisation (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007
	Health care provider identification DSS Health, Superseded 03/12/2008
	Health care provider identification DSS Health, Standard 03/12/2008

Foot deformity

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—foot deformity indicator, code N
METeOR identifier:	302449
Registration status:	Health, Standard 21/09/2005
Definition:	Whether a deformity is present on either foot, as represented by a code.
Data Element Concept:	Person—foot deformity indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described
	This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes: Record if a foot deformity is present on either foot.
	CODE 2 No: Record if no foot deformity is present on either foot.
	Common deformities include claw toes, pes cavus, hallux valgus, hallux rigidus, hammer toe, Charcot foot and nail deformity.
Collection methods:	Both feet to be examined for the presence of foot deformity.
Comments:	Foot deformities are associated with high mechanical pressure on the overlying skin that lead to ulceration in the absence of protective pain sensation and when shoes are unsuitable. Limited joint mobility is often present, with displaced plantar fat pad and more prominent metatarsal heads.

Source and reference attributes

Submitting organisation:	National diabetes data working group

Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary
Reference documents:	Lesley V Campbell, Antony R Graham, Rosalind M Kidd, Hugh F Molloy, Sharon R O'Rourke and Stephen Colagiuri: The Lower Limb in People With Diabetes; Content 1997/98 Australian Diabetes Society. Edmonds M, Boulton A, Buckenham T, et al. Report of the Diabetic Foot and Amputation Group. Diabet Med 1996; 13: S27 - 42. Reiber GE. Epidemiology of the diabetic foot. In: Levin ME, O'Neal LW, Bowker JH, editors. The diabetic foot. 5th ed. St Louis: Mosby Year Book, 1993; 1 - 5. Most RS, Sinnock P. The epidemiology of lower limb extremity amputations in diabetic individuals. Diabetes Care 1983; 6: 87 - 91. Therapeutic Guidelines Limited (05.04.2002) Management plan for diabetes.

Relational attributes

Related metadata references:	Supersedes Person—foot deformity status, code N Health, Superseded 21/09/2005
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Standard 21/09/2005

Foot lesion (active)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—foot lesion indicator (active), code N
METeOR identifier:	302437
Registration status:	Health, Standard 21/09/2005
Definition:	Whether an individual has an active foot lesion, other than an ulcer, on either foot, as represented by a code.
Data Element Concept:	Person—foot lesion indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described
	This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes: Record if current active foot lesion other than ulceration is present on either foot.
	CODE 2 No: Record if no current active foot lesion other than ulceration is present on either foot.
	The following entities would be included: fissures, infections, inter-digital maceration, corns, calluses and nail dystrophy.
Collection methods:	Assess whether the individual has an active foot lesion on either foot.

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:	Supersedes Person—foot lesion status (active), code N Health, Superseded 21/09/2005
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Standard 21/09/2005

Foot ulcer (history)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—foot ulcer indicator (history), code N
METeOR identifier:	302819
Registration status:	Health, Standard 21/09/2005
Definition:	Whether person has a previous history of ulceration on either foot, as represented by a code.
Data Element Concept:	Person—foot ulcer indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes: Record if person has a previous history of ulceration on either foot. CODE 2 No: Record if person has no previous history of ulceration on either foot.
Collection methods:	Ask the individual if he/she a previous history of foot ulceration. Alternatively obtain this information from appropriate documentation.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references:	Supersedes Person—foot ulcer history status, code N Health, Superseded 21/09/2005
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Standard 21/09/2005

Foot ulcer (current)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—foot ulcer indicator (current), code N
METeOR identifier:	302445
Registration status:	Health, Standard 21/09/2005
Definition:	Whether an individual has a current foot ulcer on either foot, as represented by a code.
Data Element Concept:	Person—foot ulcer indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 9 Not stated/inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes: Record if a foot ulcer is currently present on either foot.

CODE 2 No: Record if a foot ulcer is not currently present on either foot.

Collection methods:

Access whether the individual has a current foot ulcer on either foot.

Assessment

- ask the patient about previous or current foot problems, neuropathic symptoms, rest pain and intermittent claudication;
- inspect the feet (whole foot, nails, between the toes) to identify active foot problems and the 'high-risk foot';
- assess footwear;

- check peripheral pulses;
- examine for neuropathy by testing reflexes and sensation preferably using tuning fork, 10 g monofilament and/or biothesiometer.

Comments:

Foot ulcer is usually situated on the edge of the foot or toes because blood supply is the poorest at these sites. In a purely vascular ulcer, nerve function is normal and sensation is intact, hence vascular ulcers are usually painful.

Foot ulcers require urgent care from an interdisciplinary team, which may include a general practitioner, podiatrist, endocrinologist physician, nurse or surgeon.

Source and reference attributes

Submitting organisation: National diabetes data working group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Reference documents: The Diabetic Foot Vol 3 No 4. Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus.

Relational attributes

Related metadata references: Supersedes Person—foot ulcer status (current), code N Health, Superseded 21/09/2005

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Standard 21/09/2005

Formal community support access status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—formal community support access indicator (current), code N
METeOR identifier:	270169
Registration status:	Health, Standard 01/03/2005
Definition:	Whether a person is currently accessing a formal community support service or services, as represented by a code.
Data Element Concept:	Person—formal community support access indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Currently accessing
	2	Currently not accessing
Supplementary values:	9	Not known/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1:

The person is currently accessing at least one paid community support service (i.e. meals on wheels, home help, in-home respite, service packages, district nursing services, etc).

CODE 2:

The person is not currently accessing any paid community support service or services.

CODE 9:

The person's current status with regards to accessing community support services is not known or inadequately described for more specific coding.

Source and reference attributes

Submitting organisation:	Cardiovascular Data Working Group

Relational attributes

Related metadata references:	Supersedes Formal community support access status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.5 KB)
Implementation in Data Set Specifications:	Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006
	Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007
	Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009
	Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Full-time equivalent staff (mental health)—all staff

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (mental health)—full-time equivalent staff (paid), total N[NNN{.N}]
METeOR identifier:	296553
Registration status:	Health, Standard 08/12/2004
Definition:	The aggregate full-time equivalent staff units paid for all staffing categories within a mental health establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Guide for use:	The total is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. 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.
Collection methods:	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. Where staff provide services to more than one hospital (for Public

hospitals NMDS) or service unit (for Mental health establishments NMDS), 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).

Comments: This metadata item 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.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Is formed using Establishment—full-time equivalent staff (paid) (other personal care staff), average N[NNN{.N}] Health, Standard 01/03/2005

Is formed using Establishment—full-time equivalent staff (paid) (domestic and other staff), average N[NNN{.N}] Health, Standard 01/03/2005

Is formed using Establishment—full-time equivalent staff (paid) (administrative and clerical staff), average N[NNN{.N}] Health, Standard 01/03/2005

Is formed using Establishment—full-time equivalent staff (paid) (enrolled nurses), average N[NNN{.N}] Health, Standard 01/03/2005

Is formed using Establishment—full-time equivalent staff (paid) (registered nurses), average N[NNN{.N}] Health, Standard 01/03/2005

Is formed using Establishment—full-time equivalent staff (paid) (consumer consultants), average N[NNN{.N}] Health, Standard 08/12/2004

Is formed using Establishment—full-time equivalent staff (paid) (carer consultants), average N[NNN{.N}] Health, Standard 08/12/2004

Is formed using Establishment—full-time equivalent staff (paid) (salaried medical officers), average N[NNN{.N}] Health, Standard 01/03/2005

Is formed using Establishment—full-time equivalent staff (paid) (diagnostic and health professionals), average N[NNN{.N}] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Full-time equivalent staff—administrative and clerical staff

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (administrative and clerical staff), average N[NNN{.N}]
METeOR identifier:	270496
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **administrative and clerical staff** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (administrative and clerical staff)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:

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 metadata item.

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 employee is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time employee who works 64 hours is 0.8. If a full-time employee 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.

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).

Comments: This metadata item 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.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.9 KB)

Is used in the formation of Establishment (mental health)—full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Full-time equivalent staff—average

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid), average N[NNN{.N}]
METeOR identifier:	270543
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all staffing categories within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:

Calculated by adding the full-time equivalents for each staffing category listed below:

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.

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).

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.

Comments: This metadata item 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.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.9 KB)

Implementation in Data Set Specifications: Community mental health establishments NMDS 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

Full-time equivalent staff—carer consultants

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (carer consultants), average N[NNN{.N}]
METeOR identifier:	296498
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of full-time equivalent staff units paid for all **carer consultants** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (carer consultants)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	Carer consultants are persons employed (or engaged via contract) on a part-time or full-time paid basis to represent the interests of carers and advocate for their needs. This implies the person received a salary or contract fee on a regular basis. It does not refer to arrangements where the carer only received reimbursements of expenses or occasional sitting fees for attendance at meetings. The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. 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. 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).
Comments:	This metadata item 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.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Is used in the formation of Establishment (mental health) — full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Full-time equivalent staff—consultant psychiatrists and psychiatrists

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (consultant psychiatrists and psychiatrists), average N[NNN{.N}]
METeOR identifier:	287509
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of full-time equivalent staff units paid for all **consultant psychiatrists and psychiatrists** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (consultant psychiatrists and psychiatrists)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	Medical officers who are registered to practice psychiatry under the relevant state or territory Medical Registration Board; or who are fellows of the Royal Australian and New Zealand College of Psychiatrists or registered with Health Insurance Commission as a specialist in Psychiatry. The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. 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 metadata items. 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).
Comments:	This metadata item 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.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Full-time equivalent staff—consumer consultants

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (consumer consultants), average N[NNN{.N}]
METeOR identifier:	296496
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of full-time equivalent staff units paid for all **consumer consultants** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (consumer consultants)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	Consumer consultants are persons employed (or engaged via contract) on a part-time or full-time paid basis to represent the interests of consumers and advocate for their needs. This implies the person received a salary or contract fee on a regular basis. It does not refer to arrangements where the consumer only received reimbursements of expenses or occasional sitting fees for attendance at meetings. The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. 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. 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).
Comments:	This metadata item 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.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Is used in the formation of Establishment (mental health) — full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Conditional obligation:
If specialised mental health service organisation-consumer participation arrangements status (consumer consultants employed) METeOR 288866 = 1, this data element must be completed.

Full-time equivalent staff—diagnostic and health professionals

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (diagnostic and health professionals), average N[NNN{.N}]
METeOR identifier:	270495
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **diagnostic and health professionals** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (diagnostic and health professionals)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:

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 metadata item includes all allied health professionals and laboratory technicians (but excludes civil engineers and computing staff). This metadata item includes full-time equivalent staff units of occupational therapists, social workers, psychologists, and other diagnostic and health professionals.

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 employee is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time employee who works 64 hours is 0.8. If a full-time employee 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.

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).

Comments: This metadata item 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.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.9 KB)

Is used in the formation of Establishment (mental health) — full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Implementation in Data Set Specifications: Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Full-time equivalent staff—domestic and other staff

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (domestic and other staff), average N[NNN{.N}]
METeOR identifier:	270498
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **domestic and other staff** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (domestic and other staff)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:

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 metadata item also includes all staff not elsewhere included (primarily maintenance staff, trades people and gardening 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 employee is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time employee who works 64 hours is 0.8. If a full-time employee 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.

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).

Comments: This metadata item 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.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.9 KB)

Is used in the formation of Establishment (mental health) — full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Full-time equivalent staff—enrolled nurses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (enrolled nurses), average N[NNN{.N}]
METeOR identifier:	270497
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **enrolled nurses** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (enrolled nurses)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:

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).

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.

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).

Comments: This metadata item 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.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.9 KB)

Is used in the formation of Establishment (mental health) — full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Implementation in Data Set Specifications: Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Full-time equivalent staff—occupational therapists

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (occupational therapists), average N[NNN{.N}]
METeOR identifier:	287603
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of full-time equivalent staff units paid for all **occupational therapists** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (occupational therapists)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	Persons who have completed a course of recognised training and are eligible for membership of the Australian Association of Occupational Therapists. The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. 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. 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).
Comments:	This metadata item 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.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Full-time equivalent staff—other diagnostic and health professionals

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (other diagnostic and health professionals), average N[NNN{.N}]
METeOR identifier:	287611
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of full-time equivalent staff units paid for all **other diagnostic and health professionals** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (other diagnostic and health professionals)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	Includes qualified staff (other than qualified medical or nursing staff) engaged in duties of a diagnostic, professional or technical nature. This metadata item covers all allied health professionals and laboratory technicians (but excludes civil engineers and computing staff). The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. 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. 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).
Comments:	This metadata item 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.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Full-time equivalent staff—other medical officers

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (other medical officers), average N[NNN{.N}]
METeOR identifier:	287531
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of full-time equivalent staff units paid for all **other medical officers** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (other medical officers)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	Medical officers employed or engaged by the organisation who are neither registered as psychiatrists within the state or territory nor formal trainees within the Royal Australian and New Zealand College of Psychiatrists Postgraduate Training Program. The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. 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 metadata items. 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).
Comments:	This metadata item 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.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Full-time equivalent staff—other personal care staff

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (other personal care staff), average N[NNN{.N}]
METeOR identifier:	270171
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **other personal care staff** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (other personal care staff)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:

This metadata item 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

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 employee is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time employee who works 64 hours is 0.8. If a full-time employee 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.

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).

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.

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).

Comments: This metadata item 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.

Source and reference attributes

Steward: Australian Bureau of Statistics (ABS)

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.9 KB)

Is used in the formation of Establishment (mental health) — full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Implementation in Data Set Specifications: Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Full-time equivalent staff—psychiatry registrars and trainees

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (psychiatry registrars and trainees), average N[NNN{.N}]
METeOR identifier:	287529
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of full-time equivalent staff units paid for all **psychiatry registrars and trainees** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (psychiatry registrars and trainees)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	Medical officers who are formal trainees within the Royal Australian and New Zealand College of Psychiatrists Postgraduate Training Program. The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. 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. 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).
Comments:	This metadata item 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.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Full-time equivalent staff—psychologists

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (psychologists), average N[NNN{.N}]
METeOR identifier:	287609
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of full-time equivalent staff units paid for all **psychologists** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (psychologists)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	Persons who are registered as psychologists with the relevant state and territory registration board. The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. 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. 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).
Comments:	This metadata item 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.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Full-time equivalent staff—registered nurses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (registered nurses), average N[NNN{.N}]
METeOR identifier:	270500
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **registered nurses** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (registered nurses)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	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. 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).
Comments:	This metadata item 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.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.9 KB)

Is used in the formation of Establishment (mental health) — full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Full-time equivalent staff—salaried medical officers

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (salaried medical officers), average N[NNN{.N}]
METeOR identifier:	270494
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **salaried medical officers** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (salaried medical officers)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:

Medical officers employed by the hospital on a full time or part time salaried basis. This excludes visiting medical officers engaged on an honorary, sessional or fee for service basis.

This metadata item includes salaried medical officers who are engaged in administrative duties regardless of the extent of that engagement (for example, clinical superintendent and medical superintendent).

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 employee is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time employee who works 64 hours is 0.8. If a full-time employee 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.

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).

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.

Comments:

This metadata item 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.

Relational attributes

Related metadata references:

Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.9 KB)

Is used in the formation of Establishment (mental health) — full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Full-time equivalent staff—social workers

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (social workers), average N[NNN{.N}]
METeOR identifier:	287607
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of full-time equivalent staff units paid for all **social workers** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (social workers)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	Persons who have completed a course of recognised training and are eligible for membership of the Australian Association of Social Workers. The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. 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. 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).
Comments:	This metadata item 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.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Full-time equivalent staff—student nurses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (student nurses), average N[NNN{.N}]
METeOR identifier:	270499
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **student nurses** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (student nurses)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	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. 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).
Comments:	This metadata item 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.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.9 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Full-time equivalent staff—trainee/pupil nurses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (trainee/pupil nurses), average N[NNN{.N}]
METeOR identifier:	270493
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **trainee/pupil nurses** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (trainee/pupil nurses)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	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. 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).
Comments:	This metadata item 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.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.9 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Functional stress ischaemic and perfusion outcome result

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Functional stress test—ischaemic and perfusion outcome result, code N
Synonymous names:	Functional stress test result
METeOR identifier:	349703
Registration status:	Health, Standard 01/10/2008
Definition:	The result of the person's functional stress test in terms of ischaemic and perfusion outcomes, as represented by a code.
Data Element Concept:	Functional stress test—ischaemic and perfusion outcome result

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	No abnormal outcome
2	Ischaemic discomfort and/or ST shift
3	Fixed perfusion or wall motion defects only
4	Reversible perfusion or wall motion defects only
5	Fixed and reversible perfusion and wall motion defects
6	Equivocal

Supplementary values:

Value	Meaning
9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Depending on the method used for the stress test, and therefore the way the results are viewed, some of these codes will not be applicable. For example where an ECG was used for the stress test codes 3, 4 and 5 will not be applicable.

CODE 1 No abnormal outcome

Use this code when the stress test result identifies no evidence of ischaemia (i.e. no typical angina pain and no ST shifts).

CODE 2 Ischaemic discomfort and/or ST shift

Use this code when the stress test result identifies either:

- Both ischaemic discomfort and ST shift greater than or equal to 1 mm (0.1 mV) (horizontal or downsloping); or
- new ST shift greater than or equal to 2 mm (0.2 mV) (horizontal or down-sloping) believed to represent ischaemia even in the absence of ischaemic discomfort.

This code only applies to stress tests where no imaging component was performed.

CODE 3 Fixed perfusion or wall motion defects only

Use this code when the stress test result identifies fixed perfusion defects only. This means the presence of non-viable myocardium with no areas of inducible ischaemia during functional stress testing.

This code only applies to stress tests where an imaging component was performed.

CODE 4 Reversible perfusion or wall motion defects only

Use this code when the stress test result identifies reversible perfusion defects only. This means the presence of inducible defects in myocardial perfusion with underlying viable myocardium in all areas.

This code only applies to stress tests where an imaging component was performed.

CODE 5 Fixed and reversible perfusion or wall motion defects

Use this code when the stress test result identifies reversible and fixed perfusion defects. This means the presence of non-viable myocardial areas, together with areas of inducible defects in reperfusion.

This code only applies to stress tests where an imaging component was performed.

CODE 6 Equivocal

Use this code when the stress test result identifies either:

- Typical ischaemic pain but no ST shift greater than or equal to 1 mm (0.1 mV) (horizontal or downsloping); OR ST shift of 1 mm (0.1 mV) (horizontal or downsloping) but no ischaemic discomfort.
- Defect on myocardial imaging of uncertain nature or significance.

Data element attributes

Relational attributes

Related metadata references:

Supersedes Person—functional stress test ischaemic result, code N Health, Superseded 01/10/2008

Implementation in Data Set Specifications:

Functional stress test cluster Health, Standard 01/10/2008

Conditional obligation:
To be provided when a functional stress test is performed.

Functional stress test assessment of cardiac perfusion

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Functional stress test—assessment of cardiac perfusion, code N[N]
Synonymous names:	Functional stress test method
METeOR identifier:	344432
Registration status:	Health, Standard 01/10/2008
Definition:	The method of functional assessment of cardiac perfusion undertaken in a person's stress test, as represented by a code.
Data Element Concept:	Functional stress test—assessment of cardiac perfusion

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Exercise tolerance
2	Pharmacological

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Exercise tolerance

Use this code when a treadmill, bicycle or arm-exercise was used to increase the cardiac work.

CODE 2 Pharmacological

Use this code when any form of pharmacologic augmentation was used to increase cardiac work. For example, dobutamine, atropine or persantin.

CODE 9 Not stated/inadequately described

Not for use in primary data collections.

Data element attributes

Relational attributes

Implementation in Data Set Specifications:

Functional stress test cluster Health, Standard 01/10/2008

Conditional obligation:
To be provided when a functional stress test is performed.

Functional stress test element

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Functional stress test—stress test element, code N
METeOR identifier:	356883
Registration status:	Health, Standard 01/10/2008
Definition:	The element included in a person's functional stress test, as represented by a code.
Data Element Concept:	Functional stress test—functional stress test element

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values: / *Supplementary values:*

Value	Meaning
1	ECG monitoring
2	Echocardiography
3	Radionuclide (perfusion) imaging (e.g. Thallium, Sestamibi)
4	Positron Emission Tomography (PET)
5	Magnetic Resonance Imaging (MRI)
9	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	More than one code may be recorded (code 9 is excluded from multiple coding).

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group

Relational attributes

Related metadata references:	Supersedes Person—functional stress test element, code N Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Functional stress test cluster Health, Standard 01/10/2008 *Conditional obligation:* To be provided when a functional stress test is performed.

Functional stress test intensity

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Functional stress test— stress test intensity, code N
METeOR identifier:	344443
Registration status:	Health, Standard 01/10/2008
Definition:	The intensity of the functional stress test performed on a person, as represented by a code.
Data Element Concept:	Functional stress test—stress test intensity

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Maximal (symptom limited)
2	Submaximal
3	Rest / distribution study

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Maximal (symptom limited)

Use this code when the intensity of the stress test is to increase the person's heart rate with the exercise to 85-90% of their predicted maximum heart rate.

CODE 2 Submaximal

Use this code when the intensity of the stress test is limited to increasing the person's heart rate with the exercise to 120 beats per minute or 70% of their predicted maximum heart rate.

CODE 3 Rest/distribution study

Use this code when a Thallium (nuclear) study has been undertaken for the assessment of viability, where no exercise or pharmacologic stress component has been undertaken

CODE 9 Not stated/inadequately described

Not for use in primary data collections.

Data element attributes

Collection and usage attributes

Collection methods: The intensity is determined and recorded by the clinicians performing the test.

Comments: The stress test intensity has implications for the interpretation of the test results.

Relational attributes

Implementation in Data Set Specifications: Functional stress test cluster Health, Standard 01/10/2008

Conditional obligation:
To be provided when a functional stress test is performed.

Functional stress test performed indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—functional stress test performed indicator, yes/no code N
METeOR identifier:	347697
Registration status:	Health, Standard 01/10/2008
Definition:	An indicator of whether a functional stress test was performed on a person, as represented by a code.
Data Element Concept:	Person—functional stress test performed indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 9 Not stated/inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use: Code 1 Yes

Record if a functional stress test was performed.

Code 2 No

Record if no functional stress test was performed.

Relational attributes

Implementation in Data Set Specifications: Functional stress test cluster Health, Standard 01/10/2008

Funding source for hospital patient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—principal source of funding, hospital code NN
METeOR identifier:	339080
Registration status:	Health, Standard 29/11/2006
Definition:	The principal source of funds for an admitted patient episode or non-admitted patient service event, as represented by a code.
Context:	Admitted patient care. Hospital non-admitted patient care.
Data Element Concept:	Episode of care—principal source of funding

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
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
13	No charge raised

Supplementary values:

Value	Meaning
99	Not known

Collection and usage attributes

Guide for use: CODE 01 Australian Health Care Agreements

Australian Health Care Agreements should be recorded as the funding source for Medicare eligible admitted patients who elect

to be treated as public patients and Medicare eligible emergency department patients and Medicare eligible patients presenting at a public hospital outpatient department for whom there is not a third party arrangement.

Includes: Public admitted patients in private hospitals funded by state or territory health authorities (at the state or regional level).

Excludes: Inter-hospital contracted patients and overseas visitors who are covered by Reciprocal health care agreements and elect to be treated as public admitted patients.

CODE 02 Private health insurance

Excludes: overseas visitors for whom travel insurance is the major funding source.

CODE 03 Self-funded

This code includes funded by the patient, by the patient's family or friends, or by other benefactors.

CODE 10 Other hospital or public authority

Includes: Patients receiving treatment under contracted care arrangements (Inter-hospital contracted patient).

CODE 11 Reciprocal health care agreements (with other countries)

Australia has Reciprocal Health Care Agreements with the United Kingdom, the Netherlands, Italy, Malta, Sweden, Finland, Norway, New Zealand and Ireland. The Agreements provide for free accommodation and treatment as public hospital services, but do not cover treatment as a private patient in any kind of hospital.

– The Agreements with Finland, Italy, Malta, the Netherlands, Norway, Sweden and the United Kingdom provide free care as a public patient in public hospitals, subsidised out-of-hospital medical treatment under Medicare, and subsidised medicines under the Pharmaceutical Benefits Scheme.

– The Agreements with New Zealand and Ireland provide free care as a public patient in public hospitals and subsidised medicines under the Pharmaceutical Benefits Scheme, but do not cover out-of-hospital medical treatment.

– Visitors from Italy and Malta are covered for a period of six months from the date of arrival in Australia only.

Excludes: Overseas visitors who elect to be treated as private patients.

CODE 12 Other funding source

Includes: Overseas visitors for whom travel insurance is the major funding source.

CODE 13 No charge

Includes: Admitted patients who are Medicare ineligible and receive public hospital services free of charge at the discretion of the hospital or the state/territory. Also includes patients who receive private hospital services for whom no accommodation or facility charge is raised (for example, when the only charges are

for medical services bulk-billed to Medicare), and patients for whom a charge is raised but is subsequently waived.

Excludes: Admitted public patients (Medicare eligible) whose funding source should be recorded as Australian Health Care Agreements or Reciprocal Health Care Agreements. Also excludes Medicare eligible non-admitted patients, presenting to a public hospital emergency department and Medicare eligible patients (for whom there is not a third party payment arrangement) presenting at a public hospital outpatient department, whose funding source should be recorded as Australian Health Care Agreements.

Also excludes patients presenting to an outpatient department who have chosen to be treated as a private patient and have been referred to a named medical specialist who is exercising a right of private practice. These patients are not considered to be patients of the hospital (see Guide for use).

Data element attributes

Collection and usage attributes

Guide for use:

If there is an expected funding source followed by a finalised actual funding source (for example, in relation to compensation claims), then the actual funding source known at the end of the reporting period should be recorded.

The expected funding source should be reported if the fee has not been paid but is not to be waived.

If a charge is raised for accommodation or facility fees for the episode/service event, the intent of this data element is to collect information on who is expected to pay, provided that the charge would cover most of the expenditure that would be estimated for the episode/service event. If the charge raised would cover less than half of the expenditure, then the funding source that represents the majority of the expenditure should be reported.

The major source of funding should be reported for nursing-home type patients.

Relational attributes

Related metadata references:

Supersedes Episode of care—expected principal source of funding, hospital code NN Health, Superseded 29/11/2006

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Admitted patient palliative care NMDS 2007-08 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient palliative care NMDS 2008-09 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient palliative care NMDS 2009-10 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient palliative care NMDS 2010-11 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Geographical location of establishment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—geographical location, code (ASGC 2009) NNNNN
METeOR identifier:	386781
Registration status:	Health, Standard 02/10/2009
Definition:	The geographical location of the main administrative centre of an establishment, as represented by a code.
Data Element Concept:	Establishment—geographic location

Value domain attributes

Representational attributes

Classification scheme:	Australian Standard Geographical Classification 2009
Representation class:	Code
Data type:	Number
Format:	NNNNN
Maximum character length:	5

Data element attributes

Collection and usage attributes

Guide for use:

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 (ASGC) (Australian Bureau of Statistics (ABS), catalogue number 1216.0). It is a composite of State identifier and SLA (first digit = State identifier, next four digits = SLA).

The Australian Standard Geographical Classification (ASGC) is updated on an annual basis with a date of effect of 1 July each year.

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.

Source and reference attributes

Origin: Australian Standard Geographical Classification (Australian Bureau of Statistics Catalogue No. 1216.0)

Relational attributes

Related metadata references: Supersedes Establishment—geographical location, code (ASGC 2008) NNNNN Health, Superseded 02/10/2009

Is formed using Establishment—Australian state/territory identifier, code N Health, Standard 01/03/2005

Implementation in Data Set Specifications: Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Geographical location of service delivery outlet

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service delivery outlet—geographic location, code (ASGC 2009) NNNNN
METeOR identifier:	386787
Registration status:	Health, Standard 02/10/2009
Definition:	Geographical location of a site from which a health/community service is delivered, as represented by a code.
Data Element Concept:	Service delivery outlet—geographic location

Value domain attributes

Representational attributes

Classification scheme:	Australian Standard Geographical Classification 2009
Representation class:	Code
Data type:	Number
Format:	NNNNN
Maximum character length:	5

Data element attributes

Collection and usage attributes

Guide for use:	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 (ASGC). It is a composite of State identifier and SLA (first digit = State identifier, next four digits = SLA). 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.
Comments:	To enable the analysis of the accessibility of service provision in relation to demographic and other characteristics of the population of a geographic area.

Source and reference attributes

Submitting organisation: Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Origin: Australian Standard Geographical Classification (ABS Cat. No. 1216.0)

Relational attributes

Related metadata references: Supersedes Service delivery outlet—geographic location, code (ASGC 2008) NNNNN Health, Superseded 02/10/2009

Is formed using Establishment—Australian state/territory identifier, code N Health, Standard 01/03/2005

Implementation in Data Set Specifications: Alcohol and other drug treatment services NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Gestational age

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Product of conception—gestational age, completed weeks N[N]
METeOR identifier:	298105
Registration status:	Health, Standard 02/12/2009
Definition:	The age of a product of conception in completed weeks.
Data Element Concept:	Product of conception—gestational age

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]
Maximum character length:	2

Supplementary values:

Value	Meaning
99	Not stated/unknown

Unit of measure: Completed weeks

Data element attributes

Collection and usage attributes

Guide for use:

Gestational age is the best clinical estimate of the duration of pregnancy at a specific point in time, based on the first day of the last menstrual period, ultrasound or physical examination of the baby.

Gestational age is conventionally expressed in completed weeks. When gestational age is calculated using the first day of the last normal menstrual period, the first day is counted as day zero and not day one. Therefore, a 25 week, 5 day fetus is considered a 25 week fetus (25+0, 25+1, 25+2, 25+3, 25+4, 25+5, 25+6).

When ultrasound is used to date a pregnancy, the earliest ultrasound examination should be used and should preferably be between 6 and 10 weeks gestation. Scans performed beyond 24 weeks gestation are unlikely to be reliable in estimating gestational age and should not be used for this purpose.

The duration of gestation can be determined from the first day of the last normal menstrual period, from ultrasound or clinical assessment. For the purpose of the national collection, gestational age is expressed in completed weeks.

The World Health Organisation 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; and
- post-term: 42 completed weeks or more (294 days or more) of gestation.

Comments: Gestational age is a key marker in pregnancy and an important risk factor for neonatal outcomes.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Origin: International Classification of Diseases and Related Health Problems, 10 Revision, WHO, 1992

Reference documents: American Academy of Pediatrics (2004) 'Policy statement - Age terminology during the perinatal period'.

Relational attributes

Related metadata references: See also Pregnancy—estimated duration (at the first visit for antenatal care), completed weeks N[N] Health, Standard 02/12/2009

Supersedes Female (pregnant)—estimated gestational age, total weeks NN Health, Superseded 02/12/2009

Implementation in Data Set Specifications: Perinatal NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Given name sequence number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (name)—given name sequence number, code N
METeOR identifier:	287595
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The numerical order of the given names or initials of a person, as represented by a code.
Data Element Concept:	Person (name)—given name sequence number

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	2

Permissible values:

Value	Meaning
1	First given name
2	Second given name
3	Third given name
4	Fourth given name
5	Fifth given name
6	Sixth given name
7	Seventh given name
8	Eighth given name
9	Ninth and subsequent given name

Data element attributes

Collection and usage attributes

Guide for use:

To be used in conjunction with Given name.
Example: Mary Georgina Smith

In the example above 'Mary' would have a given name sequence number of 1 and 'Georgina' would have a given name sequence number of 2.

Example: Jean Claude Marcel Moreaux

If the person has recorded a single given name as more than one word, displaying spaces in between the words(e.g. Jean Claude), their given names are recorded in data collection systems in the same way (i.e. Jean Claude is one given name and Marcel is another given name). 'Jean Claude' would have a Given name

sequence number of '1' and 'Marcel' would have a Given name sequence number of '2'.

Source and reference attributes

Submitting organisation: Standards Australia

Origin: AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Implementation in Data Set Specifications:

Health care client identification DSS Health, Superseded 03/12/2008

Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Superseded 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Given name(s)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (name)—given name, text [X(40)]
METeOR identifier:	287035
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 20/06/2005
Definition:	The person's identifying name within the family group or by which the person is socially identified, as represented by text.
Data Element Concept:	Person (name)—given name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(40)]
Maximum character length:	40

Data element attributes

Collection and usage attributes

Guide for use:	A person may have more than one Given name. All given names should be recorded. The agency or establishment should record the person's full given name(s) on their information systems. National Community Services Data Dictionary specific: In instances where there is uncertainty about which name to record for a person living in a remote Aboriginal or Torres Strait Islander community, Centrelink follows the practice of recording the Indigenous person's name as it is first provided to Centrelink. In situations where proof of identity is required, the name is that recorded on a majority of the higher point scoring documents that are produced as proof of identity. National Health Data Dictionary specific: Each individual Given name should have a Given name sequence number associated with it. Health care establishments may record given names (first and other given names) in one field or several fields. This metadata item definition applies regardless of the format of data recording. A full history of names is to be retained.
Collection methods:	This metadata item should be recorded for all clients. Given name(s) should be recorded in the format preferred by the

person. The format should be the same as that indicated by the person (for example written on a form) or in the same format as that printed on an identification card, such as Medicare card, to ensure consistent collection of name data.

It is acknowledged that some people use more than one given name (for example formal name, birth name, nickname or shortened name, or tribal name) depending on the circumstances. A person is able to change his or her name by usage in all States and Territories of Australia with the exception of Western Australia, where a person may only change his or her name under the Change of Name Act.

A person should generally be registered using their preferred name as it is more likely to be used in common usage and on subsequent visits to the agency or establishment. The person's preferred name may in fact be their legal (or Medicare card) name. The Person name type metadata item (see Comments) can be used to distinguish between the different types of names that may be used by the person.

The following format may assist with data collection:

What is the given name you would like to be known by?

_____

Are you known by any other given names that you would like recorded?

If so, what are they

_____

Please indicate the 'type' of given name that is to be recorded:

(a) Medicare card name (if different to preferred name).

(b) Alias (any other name that you are known by).

Whenever a person informs the agency or establishment of a change of given name (for example prefers to be know by their middle name), the former name should be recorded according to the appropriate name type. Do not delete or overwrite a previous given name. For example 'Mary Georgina Smith' informs the hospital that she prefers to be known as 'Georgina'. Record 'Georgina' as her preferred given name and record 'Mary' as the Medicare card given name.

Similarly the establishment is informed that 'Baby of Louise Jones' has been named 'Mary Jones'. Retain 'Baby of Louise' as the newborn name and also record 'Mary' as the preferred 'Given name'.

Registering an unidentified health care client:

If the person is a health care client and her/his given name is not known record unknown in the 'Given name' field and use alias Name type. When the person's name becomes known, add the actual name as preferred Name type (or other as appropriate). Do not delete or overwrite the alias name of unknown.

Use of first initial:

If the person's given name is not known, but the first letter (initial) of the given name is known, record the first letter in the preferred 'Given name' field. Do not record a full stop following the initial.

Persons with only one name:

Some people do not have a **family** name and a given name: they have only one name by which they are known. If the person has only one name, record it in the 'Family name' field and leave the 'Given name' blank.

Record complete information:

All of the person's given names should be recorded.

Shortened or alternate first given name:

If the person uses a shortened version or an alternate version of their first given name, record their preferred name, the actual name as their Medicare card name and any alternative versions as alias names as appropriate.

Example - The person's given name is Jennifer but she prefers to be called Jenny. Record 'Jenny' as the preferred 'Given name' and 'Jennifer' as her Medicare card name.

Example - The person's given name is 'Giovanni' but he prefers to be called 'John'.

Record 'John' as the preferred 'Given name' and 'Giovanni' as the Medicare card name.

Punctuation:

If special characters form part of the given names they shall be included, e.g. hyphenated names shall be entered with the hyphen.

- Hyphen, for example Anne-Maree, Mary-Jane

Do not leave a space before or after the hyphen, that is between last letter of 'Anne' and the hyphen, nor a space between the hyphen and the first letter of 'Maree'.

- spaces, for example Jean Claude Marcel Moreaux

If the person has recorded their given name as more than one word, displaying spaces in between the words, record their given names in data collection systems in the same way (that is Jean Claude is one given name and Marcel is another given name).

Names not for continued use:

For cultural reasons, a person such as an Aboriginal or Torres Strait Islander may advise that they are no longer using the given name they previously used and are now using an alternative current name. Record their current name as their preferred given name and record their previously used name as an alias name (with a Name conditional use flag of 'not for continued use').

Composite name:

If a person identifies their first name as being a composite word, both parts should be recorded under the first Given Name (rather than the first and second Given Name).
If 'Anne Marie Walker' notes her preferred Given Name to be 'Anne Marie', then 'Anne Marie' is recoded as (first) Given Name, and (second) Given Name is left blank.

Registering an unnamed newborn baby:

An unnamed (newborn) baby is to be registered using the mother's given name in conjunction with the prefix 'Baby of'. For example, if

the baby's mother's given name is Fiona, then record 'Baby of Fiona' in the preferred 'Given name' field for the baby. This name is recorded under the newborn Name type. If a name is subsequently given, record the new name as the preferred given name and retain the newborn name.

Registering unnamed multiple births:

An unnamed (newborn) baby from a multiple birth should use their mother's given name plus a reference to the multiple births. For example, if the baby's mother's given name is 'Fiona' and a set of twins is to be registered, then record 'Twin 1 of Fiona' in the Given name field for the first born baby, and 'Twin 2 of Fiona' in the 'Given name' field of the second born baby. Arabic numbers (1, 2, 3 ...) are used, not Roman Numerals (I, II, III .....).

In the case of triplets or other multiple births the same logic applies. The following terms should be use for recording multiple births:

- Twin:

use Twin, that is Twin 1 of Fiona

- Triplet:

use Trip, that is Trip 1 of Fiona

- Quadruplet:

use Quad, that is Quad 1 of Fiona

- Quintuplet:

use Quin, that is Quin 1 of Fiona

- Sextuplet:

use Sext, that is Sext 1 of Fiona

- Septuplet:

use Sept, that is Sept 1 of Fiona.

These names should be recorded under the newborn Person name type. When the babies are named, the actual names should be recorded as the preferred name. The newborn name is retained.

Ethnic Names:

The Centrelink Naming Systems for Ethnic Groups publication provides the correct coding for ethnic names. Refer to Ethnic Names Condensed Guide for summary information.

Misspelled given names:

If the person's given name has been misspelled in error, update the Given name field with the correct spelling and record the misspelled given name as an Alias name. Recording misspelled names is important for filing documents that may be issued with previous versions of the client's name. Discretion should be used regarding the degree of recording that is maintained.

Comments:

Often people use a variety of names, including legal names, married/maiden names, nicknames, assumed names, traditional names, etc. Even small differences in recording - such as the difference between Thomas and Tom - can make Record linkage impossible. To minimise discrepancies in the recording and reporting of name information, agencies or establishments should

ask the person for their full (formal) Given name and Family name. These may be different from the name that the person may prefer the agency or establishment workers to use in personal dealings. Agencies or establishments may choose to separately record the preferred name that the person wishes to be used by agency or establishment workers. In some cultures it is traditional to state the family name first. To overcome discrepancies in recording/reporting that may arise as a result of this practice, agencies or establishments should always ask the person to specify their first given name and their family or surname separately. These should then be recorded as Given name and Family name as appropriate, regardless of the order in which they may be traditionally given.

National Community Services Data Dictionary specific:

Selected letters of the given name in combination with selected letters of the family name, date of birth and sex may be used for **record linkage** for statistical purposes only.

National Health Data Dictionary specific:

Health care provider identification DSS and Health care client identification DSS
For the purpose of positive identification or contact, agencies or establishments that collect Given name should also collect Given name sequence number. Given name sequence number is also a metadata item in Australian Standard AS4846-2004 Health care provider identification and is proposed for inclusion in the review of Australian Standard AS5017-2002 Health care client identification. AS5017 and AS4846 use alternative alphabetic codes for Given name sequence number. Refer to the current standards for more details.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Standards Australia

Origin: National Health Data Committee

National Community Services Data Committee

Commonwealth Department of Health and Family Services 1998. Home and Community Care Data Dictionary Version 1.0. Canberra: DHFS

Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Reference documents: AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references: Supersedes Person (name)—given name, text [X(40)] Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005

See also Person (name)—family name, text X[X(39)] Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 20/06/2005

Is used in the formation of Person (name)—letters of name, text

	XXXXX Community services, Standard 14/09/2009
	Is used in the formation of Person—letters of given name, text XX Community services, Standard 27/03/2007
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005
	Cancer (clinical) DSS Health, Superseded 06/03/2009
	Cancer (clinical) DSS Health, Superseded 22/12/2009
	Cancer (clinical) DSS Health, Standard 22/12/2009
	Health care client identification DSS Health, Superseded 03/12/2008
	Health care client identification DSS Health, Standard 03/12/2008
	Health care provider identification DSS Health, Superseded 04/07/2007
	Health care provider identification DSS Health, Superseded 03/12/2008
	Health care provider identification DSS Health, Standard 03/12/2008

Glycoprotein IIb/IIIa receptor antagonist (status)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—glycoprotein IIb/IIIa receptor antagonist status, code NN
METeOR identifier:	285115
Registration status:	Health, Standard 04/06/2004
Definition:	The person's glycoprotein IIb/IIIa receptor antagonist therapy status, as represented by a code.
Data Element Concept:	Person—glycoprotein IIb/IIIa receptor antagonist status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
10	Given
21	Not given - therapy not indicated
22	Not given - patient refusal
23	Not given - known intracranial neoplasm
24	Not given - active or recent (within 2 to 4 weeks) internal bleeding (does not include menses). Suspected aortic dissection
25	Not given - history of prior cerebrovascular accident or known intracerebral pathology not covered in contraindications
26	Not given - recent trauma (within 2 to 4 weeks), including head trauma, traumatic or prolonged (greater than 10 minutes) CPR, or major surgery (less than 3 weeks)
27	Not given - pregnancy
28	Not given - other

Supplementary values:

Value	Meaning
90	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:

This metadata item pertains to the administering of Glycoprotein IIb/IIIa receptor antagonist drugs at any time point during this current event.

CODES 21 - 28 Not given

If recording 'Not given', record the principal reason if more than one code applies.

Source and reference attributes

Submitting organisation:

Acute coronary syndrome data working group

Steward:

The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:

Supersedes Glycoprotein IIb/IIIa receptor antagonist status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Glycosylated Haemoglobin—upper limit of normal range (percentage)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range of glycosylated haemoglobin, percentage N[N].N
METeOR identifier:	270333
Registration status:	Health, Standard 01/03/2005
Definition:	Laboratory standard for the value of glycosylated haemoglobin (HbA1c) measured as a percentage that is the upper boundary of the normal range.
Data Element Concept:	Laboratory standard—upper limit of normal range of glycosylated haemoglobin

Value domain attributes

Representational attributes

Representation class:	Percentage
Data type:	Number
Format:	N[N].N
Maximum character length:	3

Supplementary values:

Value	Meaning
99.9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the HbA1c normal reference range from the laboratory result.
Collection methods:	This value is usually notified in patient laboratory results and may vary for different laboratories.
Comments:	HbA1c results vary between laboratories; use the same laboratory for repeated testing.

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:

See also Person—glycosylated haemoglobin level (measured), percentage N[N].N Health, Standard 01/03/2005

Supersedes Glycosylated Haemoglobin (HbA1c) - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.9 KB)

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008
	Diabetes (clinical) DSS Health, Superseded 21/09/2005
	Diabetes (clinical) DSS Health, Standard 21/09/2005

Glycosylated haemoglobin level (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—glycosylated haemoglobin level (measured), percentage N[N].N
METeOR identifier:	270325
Registration status:	Health, Standard 01/03/2005
Definition:	A person's glycosylated haemoglobin (HbA1c) level, measured as percentage.
Data Element Concept:	Person—glycosylated haemoglobin level

Value domain attributes

Representational attributes

Representation class:	Percentage
Data type:	Number
Format:	N[N].N
Maximum character length:	3

Supplementary values:

Value	Meaning
99.9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

HbA1c results vary between laboratories; use the same laboratory for repeated testing.

When reporting, record absolute result of the most recent HbA1c level in the last 12 months.

Record the absolute result of the test (%).

Collection methods:

Test is performed in accredited laboratories:

- A single blood sample is sufficient and no preparation of the patient is required.
- Measure HbA1c ideally using High Performance Liquid Chromatography (HPLC).

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.
Reference documents:	Koening, R. J. Peterson, CM and Kilo, C et al. Hemoglobin A1c as an indicator of the degree of glucose intolerance in diabetes. Diabetes 259 (1976): 230-232.
	Nathan, D.M., Singer, D.E, Hurxthal, K, and Goodson, J.D. The clinical information value of the glycosylated hemoglobin assay. N. Eng. J. Med. 310 (1984): 341-346.

Relational attributes

Related metadata references:	See also Laboratory standard—upper limit of normal range of glycosylated haemoglobin, percentage N[N].N Health, Standard 01/03/2005
	Supersedes Glycosylated Haemoglobin (HbA1c) - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.0 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008
	Diabetes (clinical) DSS Health, Superseded 21/09/2005
	Diabetes (clinical) DSS Health, Standard 21/09/2005

Goal of care

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Community nursing service episode—goal of care, code NN
METeOR identifier:	270225
Registration status:	Health, Standard 01/03/2005
Definition:	The goal or expected outcome of a plan of care, negotiated by the service provider and recipient, as represented by a code.
Data Element Concept:	Community nursing service episode—goal of care

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
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

Collection and usage attributes

Guide for use:

CODE 01 Well person for preventative/maintenance/health promotion program

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.

CODE 02 Person will make a complete recovery

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;
- persons with **disability** or established health problem normally independent of health services, and currently recovering from an acute condition or illness as above.

CODE 03 Person will not make a complete recovery; but will rehabilitate to a state where formal on-going service is no longer required

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.

CODE 04 Person has a long-term care need and the goal is aimed at on-going support to maintain at home

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.

CODE 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

Refers to persons whose focus of care is palliation of symptoms and facilitation of the choice to die at home.

CODE 06 Person is unable to remain at home for extended period and goal is aimed at institutionalisation at a planned and appropriate time

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 institutional 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.

CODE 07 For assessment only/not applicable

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.

Data element attributes

Collection and usage attributes

Guide for use: Only one option is permissible and where Code 07 is selected, Code 9 must be used in the metadata item Community nursing service episode—nursing interventions, code N.

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.

Comments: Agencies who had previously implemented this metadata item should note changes to the code set in the Value domain.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Relational attributes

Related metadata references: Supersedes Goal of care, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (23.1 KB)

Grants to non-government organisations—accommodation services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—accommodation services grants to non-government organisations, total Australian currency N[N(8)]
METeOR identifier:	296547
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for the provision of accommodation services, defined as housing services that are linked to support services for people affected by a mental health issue.
Data Element Concept:	Specialised mental health service organisation—accommodation services grants to non-government organisations

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:

Where the exact dollar amount, for accommodations services as a whole, is unable to be provided an estimate should be derived from available local information.

Note: Only subtypes 3 and 5 are included as 'Accommodation services' for the Mental Health Establishments NMDS. Subtypes 1, 2 and 4 are not included as 'Accommodation services' for this NMDS. Categories 3 and 5 listed below are to be reported in aggregate. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under the other and unspecified services grants to non-government organisations data element.

Accommodation services are subcategorised into 5 subtypes:

1. *Crisis/interim accommodation* - Short-term accommodation which may be staffed up to 24 hours a day, seven days a week for people affected by a mental health issue. Accommodation is facility based/residential with an

average of 4-8 beds. Length of stay is generally limited to a maximum of three months.

2. *Transitional supported accommodation* - Short to medium accommodation (3-12 months) that is provided in a residential/facility based setting.
3. *Headleasing* - Provides a supportive landlord service that assists tenants to access and maintain suitable accommodation and maintains their tenancies and which is linked to support.
4. *Residential rehabilitation* - Short to long-term residential facility based accommodation provided to people with high needs. Staff support is provided.
5. *Long term supported accommodation* – Secure/tenured long-term accommodation with staff support as necessary or desired.

Collection methods:

Grants for accommodation services are to be reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health, Superseded 07/12/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Grants to non-government organisations—advocacy services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—advocacy services grants to non-government organisations, total Australian currency N[N(8)]
METeOR identifier:	286911
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for the provision of advocacy services, defined as services that provide assistance to people affected by a mental health issue to access their human and legal rights and promote reform.
Data Element Concept:	Specialised mental health service organisation—advocacy services grants to non-government organisations

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:

Where the exact dollar amount for advocacy services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.

Advocacy services are subcategorised into 2 subtypes, however data are not expected to be reported at this level:

1. *Systemic* - The representation and promotion of the rights, views and responsibilities of people affected by mental health issues in the community, public and private sectors at both domestic and international levels.
2. *Individual* - The representation and promotion of the rights and views of the individual affected by a mental health issue.

Collection methods:

Grants for advocacy services are to be reported at the lowest statistical unit level which the expenditure occurred

(state/territory or region), and should not be counted at more than one level.

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health, Superseded 07/12/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Grants to non-government organisations—community awareness/health promotion services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—community awareness/health promotion services grants to non-government organisations (financial year), total Australian currency N[N(8)]
METeOR identifier:	287011
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for community awareness/health promotion services, defined as services aimed at raising awareness about mental health/illness and those affected by mental health issues through the provision of information and/or education to the community, in order to enhance the community's capacity to support people affected by a mental health issue.
Data Element Concept:	Specialised mental health service organisation—community awareness/health promotion services grants to non-government organisations

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Where the exact dollar amount for community awareness/health promotion services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.
Collection methods:	Grants for community awareness/health promotion services are to be reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

Related metadata references:

See also Specialised mental health service organisation—other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health, Superseded 07/12/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Grants to non-government organisations—counselling services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—counselling services grants to non-government organisations, total Australian currency N[N(8)]
METeOR identifier:	287021
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for counselling services provided by professionals and non-professionals that provide emotional support, psychological support, assistance with achieving goals and the strengthening of community and social networks for people affected by a mental health issue.
Data Element Concept:	Specialised mental health service organisation—counselling services grants to non-government organisations

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Where the exact dollar amount for counselling services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.
Collection methods:	Grants for counselling services are to be reported only at the level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	See also Specialised mental health service organisation—other and unspecified services grants to non-government

organisations, total Australian currency N[N(8)] Health, Superseded 07/12/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Grants to non-government organisations—independent living skills support services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—independent living skills support services grants to non-government organisations, total Australian currency N[N(8)]
METeOR identifier:	296480
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for services that provide encouragement and support of people living with a mental health issue to participate actively in their day to day living in a community.
Data Element Concept:	Specialised mental health service organisation—independent living skills support services grants to non-government organisations

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Where the exact dollar amount for independent living skills support services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.
Collection methods:	Grants for independent living skills support services are to be reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

Related metadata references:	See also Specialised mental health service organisation—other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health, Superseded 07/12/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Grants to non-government organisations—other and unspecified mental health services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—other and unspecified mental health services grants to non-government organisations, total Australian currency N[N(8)]
METeOR identifier:	306250
Registration status:	Health, Standard 07/12/2005
Definition:	Grants made to non-government organisations for provision of mental health services not elsewhere classified and grants not allocatable to specific service types.
Data Element Concept:	Specialised mental health service organisation—other and unspecified mental health services grants to non-government organisations

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Where the exact dollar amount for other and unspecified mental health services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific mental health service types, the value of grants not allocatable to specific mental health service types should be included. Grants for mental health services classified elsewhere are listed below under Relational metadata attributes.
Collection methods:	Grants to non-government organisations for mental health services not elsewhere classified are to be reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

Related metadata references:	Supersedes Specialised mental health service organisation—other and unspecified services grants to non-government

organisations, total Australian currency N[N(8)] Health, Superseded 07/12/2005

See also Specialised mental health service organisation—self-help support groups services grants for non-government organisations, total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Specialised mental health service organisation—respite services grants to non-government organisations, total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Specialised mental health service organisation—recreation services grants to non-government organisations, total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Specialised mental health service organisation—psychosocial support services grants for non-government organisations, total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Specialised mental health service organisation—pre-vocational training services grants for non-government organisations, total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Specialised mental health service organisation—independent living skills support services grants to non-government organisations, total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Specialised mental health service organisation—counselling services grants to non-government organisations, total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Specialised mental health service organisation—community awareness/health promotion services grants to non-government organisations (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Specialised mental health service organisation—advocacy services grants to non-government organisations, total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Specialised mental health service organisation—accommodation services grants to non-government organisations, total Australian currency N[N(8)] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Grants to non-government organisations—pre-vocational training services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—pre-vocational training services grants for non-government organisations, total Australian currency N[N(8)]
METeOR identifier:	296484
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for pre-vocational training services, defined as the provision of training and skill development to individuals affected by a mental health issue to facilitate their progress into employment of their choice.
Data Element Concept:	Specialised mental health service organisation—pre-vocational training services grants for non-government organisations

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Where the exact dollar amount for pre-vocational training services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.
Collection methods:	Grants for pre-vocational training expenditure are to be reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

Related metadata references:	See also Specialised mental health service organisation—other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health, Superseded 07/12/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Grants to non-government organisations—psychosocial support services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—psychosocial support services grants for non-government organisations, total Australian currency N[N(8)]
METeOR identifier:	296486
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for psychosocial support services, defined as services that work in partnership with the individual affected by a mental health issue and their carers to provide a range of support and skill development options addressing key issues in attainment of mental health and social competence goals.
Data Element Concept:	Specialised mental health service organisation—psychosocial support services grants for non-government organisations

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Where the exact dollar amount for recreation services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.
Collection methods:	Grants for recreation expenditure are to be reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

Related metadata references:	See also Specialised mental health service organisation—other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health, Superseded 07/12/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Grants to non-government organisations—recreation services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—recreation services grants to non-government organisations, total Australian currency N[N(8)]
METeOR identifier:	296488
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for recreation services, defined as services that provide and/or facilitate a range of leisure and social opportunities to people affected by a mental health issue to enhance their social competence.
Data Element Concept:	Specialised mental health service organisation—recreation services grants to non-government organisations

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Where the exact dollar amount for recreation services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.
Collection methods:	Grants for recreation expenditure are to be reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

Related metadata references:	See also Specialised mental health service organisation—other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health, Superseded 07/12/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Grants to non-government organisations—respite services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—respite services grants to non-government organisations, total Australian currency N[N(8)]
METeOR identifier:	296490
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for respite services, defined as the provision of services that allow a planned break from the usual caring environment.
Data Element Concept:	Specialised mental health service organisation—respite services grants to non-government organisations

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Where the exact dollar amount for respite services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.
Collection methods:	Grants for respite expenditure are to be reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

Related metadata references:	See also Specialised mental health service organisation—other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health, Superseded 07/12/2005
Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Grants to non-government organisations—self-help support group services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—self-help support groups services grants for non-government organisations, total Australian currency N[N(8)]
METeOR identifier:	296492
Registration status:	Health, Standard 08/12/2004
Definition:	Grants made to non-government organisations for self-help groups support services, defined as the provision of opportunities for people affected by a mental health issue to learn from and support each other.
Data Element Concept:	Specialised mental health service organisation—self-help support groups services grants for non-government organisations

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Where the exact dollar amount for self-help support groups services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.
Collection methods:	Grants for self-help support group expenditure are to be reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

Related metadata references:	See also Specialised mental health service organisation—other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health, Superseded 07/12/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Gross capital expenditure (accrual accounting)—buildings and building services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (accrual accounting) (buildings and building services) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270521
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of buildings and building services (including plant).
Data Element Concept:	Establishment—gross capital expenditure (accrual accounting) (buildings and building services)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Gross capital expenditure (accrual accounting)—constructions

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (accrual accounting) (constructions) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270526
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of constructions (other than buildings).
Data Element Concept:	Establishment—gross capital expenditure (accrual accounting) (constructions)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Gross capital expenditure (accrual accounting)—equipment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (accrual accounting) (equipment) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270525
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of equipment.
Data Element Concept:	Establishment—gross capital expenditure (accrual accounting) (equipment)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Gross capital expenditure (accrual accounting)—information technology

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (accrual accounting) (information technology) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270527
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of information technology.
Data Element Concept:	Establishment—gross capital expenditure (accrual accounting) (information technology)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Gross capital expenditure (accrual accounting)—intangible assets

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (accrual accounting) (intangible assets) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270522
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of intangible assets.
Data Element Concept:	Establishment—gross capital expenditure (accrual accounting) (intangible assets)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Gross capital expenditure (accrual accounting)—land

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (accrual accounting) (land) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270528
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of land.
Data Element Concept:	Establishment—gross capital expenditure (accrual accounting) (land)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Gross capital expenditure (accrual accounting)—major medical equipment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (accrual accounting) (major medical equipment) (financial year), total Australian currency N[N(8)]
METeOR identifier:	269968
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of major medical equipment.
Data Element Concept:	Establishment—gross capital expenditure (accrual accounting) (major medical equipment)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Gross capital expenditure (accrual accounting)—other equipment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (accrual accounting) (other equipment) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270523
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of other equipment, such as furniture, art objects, professional instruments and containers.
Data Element Concept:	Establishment—gross capital expenditure (accrual accounting) (other equipment)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Gross capital expenditure (accrual accounting)—transport

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (accrual accounting) (transport) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270524
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of transport.
Data Element Concept:	Establishment—gross capital expenditure (accrual accounting) (transport)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Gross capital expenditure—computer equipment/installations

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (computer equipment/installations) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270520
Registration status:	Health, Standard 01/03/2005
Definition:	Gross capital expenditure, measured in Australian dollars, on computer equipment/installations.
Data Element Concept:	Establishment—gross capital expenditure (computer equipment/installations)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.4 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Gross capital expenditure—intangible assets

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (intangible assets) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270517
Registration status:	Health, Standard 01/03/2005
Definition:	Gross capital expenditure, measured in Australian dollars, in relation to intangible assets.
Data Element Concept:	Establishment—gross capital expenditure (intangible assets)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.4 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Gross capital expenditure—land and buildings

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (land and buildings) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270519
Registration status:	Health, Standard 01/03/2005
Definition:	Gross capital expenditure, measured in Australian dollars, on land and buildings.
Data Element Concept:	Establishment—gross capital expenditure (land and buildings)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.4 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Gross capital expenditure—major medical equipment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (major medical equipment) (financial year), total Australian currency N[N(8)]
METeOR identifier:	269966
Registration status:	Health, Standard 01/03/2005
Definition:	Gross capital expenditure, measured in Australian dollars, on major medical equipment.
Data Element Concept:	Establishment—gross capital expenditure (major medical equipment)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.4 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Gross capital expenditure—other

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (other capital expenditure) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270516
Registration status:	Health, Standard 01/03/2005
Definition:	Other gross capital expenditure, measured in Australian dollars, which are not included elsewhere.
Data Element Concept:	Establishment—gross capital expenditure (other capital expenditure)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.4 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Gross capital expenditure—plant and other equipment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—gross capital expenditure (plant and other equipment) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270518
Registration status:	Health, Standard 01/03/2005
Definition:	Gross capital expenditure, measured in Australian dollars, on plant and other equipment.
Data Element Concept:	Establishment—gross capital expenditure (plant and other equipment)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to the nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.4 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Group sessions (public psychiatric, alcohol and drug hospital)—emergency and outpatient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (public psychiatric or alcohol and drug hospital)—number of group session occasions of service for non-admitted patients (emergency and outpatient), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care (public psychiatric, alcohol & drug) - emergency and outpatient group sessions
METeOR identifier:	270217
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the emergency and outpatient functional unit of a public psychiatric hospital or an alcohol and drug hospital.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:	Emergency patients and outpatients are persons who receive non-admitted care. Group session non-admitted care is care provided to persons who receive direct care within the **emergency department** or other designated clinics within the hospital and who are not formally admitted at the time when the care is provided. A person 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.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Type of non-admitted patient care (public psychiatric, alcohol & drug), version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.1 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Group sessions (public psychiatric, alcohol and drug hospital)—outreach and community

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (public psychiatric or alcohol and drug hospital)—number of group session occasions of service for non-admitted patients (outreach and community), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care (public psychiatric, alcohol & drug) - outreach and community group sessions
METeOR identifier:	270219
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the outreach and community functional unit of a public psychiatric hospital or an alcohol and drug hospital.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:	For outreach/community patients, care is delivered by hospital employees to the patient in the home, place of work or other non-hospital site.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Type of non-admitted patient care (public psychiatric, alcohol & drug), version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.1 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Group sessions—alcohol and other drug

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (alcohol and drug), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - alcohol and other drug group sessions
METeOR identifier:	270479
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group session to non-admitted patients in the alcohol and drug functional unit of an establishment.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:	Each group is to be counted once, irrespective of size or the number of staff providing services. 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.
Comments:	This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests. This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care 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.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Group sessions—allied health services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (allied health services), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - allied health services group sessions
METeOR identifier:	270480
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in allied health services functional units or clinics of an establishment.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:	Allied health services include units primarily concerned with physiotherapy, family planning, dietary advice, optometry, occupational therapy, and so on. Each group is to be counted once, irrespective of size or the number of staff providing services. 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:	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.

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.

This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care 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.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Group sessions—community health services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (community health services), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - community health services group sessions
METeOR identifier:	270491
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the community health services functional unit of an establishment.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:	Community health services include units primarily concerned with baby clinics, immunisation clinics, aged care assessment teams, and so on. Each group is to be counted once, irrespective of size or the number of staff providing services. 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:	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.

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.

This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care 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.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Group sessions—dental

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (dental), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - dental group sessions
METeOR identifier:	270488
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group session to non-admitted patients in the dental unit of an establishment
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:	Each group is to be counted once, irrespective of size or the number of staff providing services. 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:	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.
Comments:	This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care 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.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Group sessions—dialysis

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (dialysis), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - dialysis group sessions
METeOR identifier:	270368
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the dialysis unit of an establishment.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:	Where patients receive treatment in a ward or clinic classified elsewhere (for example Emergency Department), they are to be counted as dialysis patients and are to be excluded from other categories. All forms of dialysis that are undertaken as a treatment necessary for renal failure are to be included. Each group is to be counted once, irrespective of size or the number of staff providing services. 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:	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.
Comments:	This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in

various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care 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.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Group sessions—district nursing services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (district nursing services), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - district nursing services group sessions
METeOR identifier:	270482
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients by the district nursing service of an establishment.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:

District nursing services:

- are for medical/nursing/psychiatric care
- are provided by a nurse, paramedic or medical officer
- involve travel by the service provider
- exclude care provided by staff from a unit classified in the community health category.

Each group is to be counted once, irrespective of size or the number of staff providing services.

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: 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.

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.

This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care 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.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Group sessions—emergency services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (emergency services), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - emergency services group sessions
METeOR identifier:	270485
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the designated emergency department of an establishment.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:	Each group is to be counted once, irrespective of size or the number of staff providing services. 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:	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.
Comments:	This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care 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.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Group sessions—endoscopy and related procedures

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (endoscopy and related procedures), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - endoscopy and related procedures group sessions
METeOR identifier:	270484
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the endoscopy and related procedures functional unit of an establishment.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:

For all occasions of endoscopy and related procedures provided as group sessions to non-admitted patients.

Endoscopy and related procedures include:

- cystoscopy
- gastroscopy
- oesophagoscopy
- duodenoscopy
- colonoscopy
- bronchoscopy
- laryngoscopy.

Each group is to be counted once, irrespective of size or the number of staff providing services.

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:

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.

Comments:

This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care 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.

Source and reference attributes

Submitting organisation:

National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Group sessions—mental health

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (mental health), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - mental health group sessions
METeOR identifier:	270490
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in designated psychiatric or mental health units of an establishment.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:	Each group is to be counted once, irrespective of size or the number of staff providing services. 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:	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.
Comments:	This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care 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.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Group sessions—other medical/surgical/diagnostic

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (other medical/surgical/diagnostic), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - other medical/surgical/diagnostic group sessions
METeOR identifier:	270487
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the medical/surgical/diagnostic functional unit of an establishment not defined elsewhere.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:	Includes ECG, obstetrics, nuclear medicine, general surgery, fertility, and so on. Each group is to be counted once, irrespective of size or the number of staff providing services. 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:	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.
Comments:	This metadata item is derived from metadata items that are not

currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care 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.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Group sessions—other outreach services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (other outreach services), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - other outreach services group sessions
METeOR identifier:	270489
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients as outreach services not classified in allied health or community health services.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:	Includes units primarily concerned with physiotherapy, speech therapy, family planning, dietary advice, optometry, occupational therapy, and so on. Each group is to be counted once, irrespective of size or the number of staff providing services. 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:	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.

Comments:

This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care 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.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Group sessions—pathology

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (pathology), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - pathology group sessions
METeOR identifier:	270481
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in designated pathology laboratories of an establishment.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:	Occasions of pathology services to all patients from other establishments should be counted separately. Each group is to be counted once, irrespective of size or the number of staff providing services. 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:	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.
Comments:	This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples

include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care 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.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Group sessions—pharmacy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (pharmacy), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - pharmacy group sessions
METeOR identifier:	270486
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the pharmacy unit of an establishment.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:	Those drugs dispensed/administered in other departments such as the emergency or outpatient are to be counted by the respective department. department Each group is to be counted once, irrespective of size or the number of staff providing services. 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:	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.
Comments:	This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples

include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care 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.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

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Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Group sessions—radiology and organ imaging

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session occasions of service for non-admitted patients (radiology and organ imaging), total N[NNNNN]
Synonymous names:	Type of non-admitted patient care - radiology and organ imaging group sessions
METeOR identifier:	270483
Registration status:	Health, Standard 01/03/2005
Definition:	A count of groups of patients/clients receiving radiology and organ imaging services in a health service establishment.
Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:	Includes x-ray department as well as specialised organ imaging clinics carrying out ultrasound, computerised tomography and magnetic resonance imaging. Each group is to be counted once, irrespective of size or the number of staff providing services. 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:	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.
Comments:	This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in

various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care 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.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Health industry relevant organisation type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health industry relevant organisation—main activity type, code NNN
METeOR identifier:	372264
Registration status:	Health, Standard 01/04/2009
Definition:	Describes a health industry relevant organisation based on its main activity, as represented by a code.
Data Element Concept:	Health industry relevant organisation—main activity type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NNN
Maximum character length:	3

Permissible values:

Value	Meaning
	Main Health Care Services organisation
101	Hospital – public
102	Hospital – private (excluding private free-standing day hospital facility)
103	Hospital – private free-standing day hospital facility (excluding private non free-standing day hospital facility)
104	Residential facility – mental health care
105	Residential facility – other
106	Provider of ambulance service
107	Medical and diagnostic laboratory
108	Clinical practices – medical – general
109	Clinical practices – medical – specialist
110	Clinical practices – medical – other
111	Clinical practices – dental
112	Clinical practices – other
113	Community health facility – substance abuse
114	Community health facility – mental
115	Community health facility – other
116	Blood and organ bank
117	Retail sale/supplier of medical goods – optical glasses and other vision products

118	Retail sale/supplier of medical goods – hearing aids
119	Retail sale/supplier of medical goods – dispensing community pharmacist
120	Retail sale/supplier of medical goods – other
121	Public health program service provider
122	General health administration service provider
123	Private health insurance
188	Other Main Health Care Service providers
198	Regional health service not further defined
199	State/territory health authority not further defined
	Secondary/non-Health Care Services organisation
201	Pharmaceutical industry
202	University
203	Non-health related insurance
204	Residential aged care facility
288	Other Secondary/non-Health Care Services organisation

Collection and usage attributes

Guide for use:

Main Health Care Service organisation

CODE 101 Hospital – public

An organisation comprised of a health care facility or group of health care facilities established under Commonwealth, state or territory legislation as a hospital or free-standing day hospital facility and authorised to provide treatment and/or care to patients. Comprises all health care facilities that are reported as public hospitals to the Public Hospital Establishments National Minimum Data Set (PHE NMDS). This includes organisations such as rehabilitation hospitals; psychiatric hospitals; mothercraft hospitals; and hospices and multi-purpose services defined as hospitals. The list of public hospitals reported to the PHE NMDS is available at www.aihw.gov.au/publications/index.cfm in the Australian Hospital Statistics annual report.

NOTE 1: Excludes providers of services where those services are not captured in the hospital financial statements. For example, the provider of a pathology or pharmacy service may be co-located within the hospital, but as a private service, and will pay the hospital for use of the site. The provider of this pathology or pharmacy service would be recorded under codes 106 to 112.

CODE 102 Hospital – private (excluding private free-standing day hospital facilities)

An organisation comprised of a health care facility or a group of health care facilities established under Commonwealth, state or territory legislation as a hospital and authorised to provide treatment and/or care to patients.

Comprises hospitals that are NOT reporting to the PHE NMDS.

NOTE: State and territory data providers are to refer to the GHE NMDS Collection Guidelines for instructions on how to report expenditure for this category.

Excludes private free-standing day hospital facilities reported under code 103.

CODE 103 Hospital - private free-standing day facility (excluding private non free-standing day hospital facilities)

An organisation comprised of one or more private free-standing day hospital facilities which provide investigation and treatment for acute conditions on a day-only basis and is approved by the Commonwealth as a hospital for the purposes of private health insurance benefits. The four main types of private free-standing day hospitals are specialist endoscopy, ophthalmic, plastic/cosmetic and general. Excludes private non free-standing day hospital facilities reported under code 102.

CODE 104 Residential facility – mental health care

An organisation comprised of one or more specialised mental health facilities primarily engaged in providing residential care to persons requiring mental health diagnosis and treatment combined with either nursing, supervisory or other types of care as required (including medical) by the residents.

Excludes residential care facilities primarily providing aged care or care for persons requiring treatment for alcohol or other substance abuse or persons with a disability.

CODE 105 Residential facility – other

Includes all government-funded facilities primarily engaged in providing residential care to persons requiring diagnosis and treatment for alcohol and other substance abuse combined with either nursing, supervisory or other types of care as required (including medical) by the residents. Includes hospices that are not defined as hospitals and respite and transitional care services.

Excludes facilities primarily providing services to aged persons or persons requiring mental health diagnosis and treatment.

Also excludes residential care facilities that report under the Commonwealth, State and Territory Disability Agreement where the primary purpose is care for persons with a disability.

CODE 106 Provider of ambulance service

Organisations primarily engaged in providing transportation of patients by ground or air, along with health (or medical) care. These services are often provided during a medical emergency but are not restricted to emergencies. The vehicles are equipped with lifesaving equipment operated by medically trained personnel. Includes organisations providing public ambulance services or flying doctor services such as Royal Flying Doctor Service and Care Flight, and support programs to assist isolated patients with travel to obtain specialised health care.

NOTE 2: Excludes providers of services where those services are captured in public or private hospital financial statements. For example, the provider of an ambulance, medical or diagnostic

laboratory, general practice, specialist medical, dental or other health practitioner service may be located within a hospital set of accounts and its expenditure recorded on the hospital financial statement. The provider of the ambulance or other service would then be recorded under code 101.

CODE 107 Medical and diagnostic laboratory

This item is not currently required to be reported by state and territory health authorities.

Organisations primarily engaged in providing analytic or diagnostic services, including body fluid analysis and diagnostic imaging, generally to the medical profession or the patient on referral from a health practitioner. Includes diagnostic imaging centres; dental or medical X-ray laboratories ultrasound services; medical testing laboratories; medical pathology laboratories; medical forensic laboratories; and X-ray clinic services. Includes public and private medical and diagnostic laboratories.

See NOTE 2 under code 106.

CODE 108 Clinical practices – medical – general

Organisations of registered medical practitioners holding the degree of a Doctor of medicine or a qualification at a corresponding level primarily engaged in the independent practice of general medicine. These practitioners operate private or group practices in their own offices (e.g., centres, clinics) or in the facilities of others, such as hospitals or medical centres.

See NOTE 2 under code 106.

This item is not currently required to be reported by state and territory health authorities.

CODE 109 Clinical practices – medical – specialist

This item is not currently required to be reported by state and territory health authorities.

Organisations of health practitioners holding the degree of a Doctor of medicine or a qualification at a corresponding level primarily engaged in the independent practice of specialist medicine or surgery, other than pathology and diagnostic imaging services. These practitioners operate a wide range of specialities in private or group practices in their own offices (e.g., centres, clinics) or in the facilities of others, such as hospitals or health maintenance type medical centres. Includes for example:

- Anaesthetist service
- Dermatology service
- Ear, nose and throat specialist service
- Gynaecology service
- Neurology service
- Obstetrics service
- Paediatric service
- Psychiatry service
- Specialist medical clinic service

- Specialist surgical service
  See NOTE 2 under code 106.

CODE 110 Clinical practices – medical – other

This item is not currently required to be reported by state and territory health authorities.

Includes organisations of physicians not able to be allocated to Codes 108 or 109

CODE 111 Clinical practices – dental

Organisations of registered health practitioners holding the degree of Doctor of dental medicine or a qualification at a corresponding level primarily engaged in the independent practice of general or specialised dentistry or dental surgery. These practitioners operate private or group practices in their own offices (e.g., centres, clinics) or in the facilities of others, such as hospitals, medical centres or community health facilities. They can provide either comprehensive preventive, cosmetic, or emergency care, or specialise in a single field of dentistry. Also included are dental hospitals providing ambulatory services only. Includes for example:

- Cleft lip and palate services
- Community dental service
- Dental assessment and treatment
- Dental hospital (out-patient)
- Dental practice service
- Dental practitioner service
- Dental surgery service
- Endodontic service
- Oral and maxillofacial services
- Oral pathology service
- Oral surgery service
- Orthodontic service
- Pedodontic service
- Periodontic service

See NOTE 2 under code 106.

CODE 112 Clinical practices – other

This item is not currently required to be reported by state and territory health authorities.

Organisations of independent health practitioners (other than physicians and dentists), such as chiropractors, optometrists, mental health specialists, physical, occupational, and speech therapists and audiologists organisations primarily engaged in providing **ambulatory** health care. These practitioners operate private or group practices in their own offices (e.g., centres, clinics) or in the facilities of others, such as hospitals or medical centres. Includes for example:

- Acupuncture service

- Aromatherapy service
- Audiology service
- Chiropractic service
- Clinical psychology service
- Dental hygiene service
- Dietician service
- Hearing aid dispensing
- Homoeopathic service
- Midwifery service
- Naturopathic service
- Nursing service
- Occupational therapy service
- Optometrist
- Osteopathic service
- Podiatry service
- Speech pathology service
- Therapeutic massage service

See NOTE 2 under code 106.

CODE 113 Community health facility – substance abuse

Organisations with health staff primarily engaged in providing ambulatory services related to the diagnosis and treatment of alcohol and other substance abuse. These are community-based organisations that treat patients who do not require admitted patient treatment. They may provide counselling staff and information regarding a wide range of substance abuse issues and/or refer patients to more extensive treatment programmes, if necessary. Includes for example:

- Community based alcoholism treatment centres and clinics (other than hospitals or residential care facilities);
- Community based detoxification centre and clinics (other than hospitals or residential care facilities);
- Community based drug addiction treatment centres and clinics (other than hospitals or residential care facilities);
- Community based substance abuse treatment centres and clinics (other than hospitals or residential care facilities).

CODE 114 Community health facility – mental

An organisation comprised of one or more specialised mental health services or facilities with health staff primarily engaged in providing ambulatory services related to the diagnosis and treatment of mental health disorders. These specialised mental health services generally treat patients who do not require admitted patient treatment. However, these services do include consultation/liaison services provided to admitted patients by community mental health services. They may provide counselling staff and information regarding a wide range of

mental health issues and/or refer patients to more extensive treatment programmes, if necessary. They may also provide treatment both on and off site, for example through mobile units. Includes only government-funded specialised mental health services, such as community mental health centres and clinics.

Includes expenditure on government-managed community specialised mental health services, plus the cost of the grants to non-government organisations that provide community specialised mental health services, not the total expenditure by these non-government organisations.

Excludes mental health clinics in hospitals and residential mental health care facilities.

CODE 115 Community health facility – other

Organisations with health staff primarily engaged in providing general or specialised ambulatory care. Centres or clinics of health practitioners with the same degree or with different degrees from more than one speciality practising within the same establishment i.e., physician and dentist) are included in this item. Includes only government-funded community health facilities such as:

- Community centres and clinics;
- General practitioner plus centres;
- Multi-speciality community clinics.

Excludes clinical practices that provide exclusively medical services or exclusively health services, ambulatory mental health and substance abuse centres, and free-standing ambulatory surgical centres (reported under codes 108 to 114) and kidney dialysis centres and clinics (reported under codes 101 to 103 if part of a hospital or code 109 if they are free-standing ambulatory centres).

CODE 116 Blood and organ bank

This item is not currently required to be reported by state and territory health authorities.

Organisations primarily engaged in collecting, storing and distributing blood and blood products and storing and distributing body organs.

CODE 117 Retail sale/supplier of medical goods – optical glasses and other vision products

This item is not currently required to be reported by state and territory health authorities.

Organisations primarily engaged in the retail sale of optical glasses and other vision products to the general public for personal or household consumption or utilisation. This includes the fitting and repair provided in combination with sales of optical glasses and other vision products.

Excludes organisations primarily engaged in providing optometric services.

CODE 118 Retail sale/supplier of medical goods – hearing aids

This item is not currently required to be reported by state and

territory health authorities.

Organisations primarily engaged in the sale of hearing aids to the general public for personal or household consumption or utilisation. This includes the fitting and repair provided in combination with the sale of hearing aids.

Excludes organisations primarily engaged in hearing testing where that also includes a component of hearing aid dispensing and fitting.

CODE 119 Retail sale/supplier of medical goods – dispensing community pharmacist

This item is not currently required to be reported by state and territory health authorities.

Organisations primarily engaged in the retail sale of pharmaceuticals to the general public for personal or household consumption or utilisation. Instances when the processing of medicine may be involved should be only incidental to selling. This includes both medicines with and without prescription.

Excludes organisations listed under code 201.

CODE 120 Retail sale/supplier of medical goods – other

This item is not currently required to be reported by state and territory health authorities.

Organisations primarily engaged in the sale of medical appliances other than optical goods and hearing aids to the general public with or without prescription for personal or household consumption or utilisation. Included are:

- Organisations primarily engaged in the manufacture of medical appliances but where the fitting and repair is usually done in combination with manufacture of medical appliances.
- Organisations engaged in the retail sale of other miscellaneous medical goods to the general public for personal or household consumption or utilisation (included are sales other than by shops, such as electronic shopping and mail-order houses).
  Illustrative examples
- sale of fluids (e.g. for home dialysis);
- all other miscellaneous health and personal care stores;
- all other sale of pharmaceuticals and medical goods;
- electronic shopping and mail-order houses specialised in medical goods.

CODE 121 Provision and administration of public health program

Organisations engaged in government or private administration and provision of public health programs such as health promotion, organised screening, immunisation and health protection programs.

CODE 122 General health administration

Organisations primarily engaged in the regulation of activities of

agencies that provide health care, overall administration of health policy, and health insurance. This item comprises government administration (excluding social security) primarily engaged in the formulation and administration of government policy in health and in the setting and enforcement of standards for medical and paramedical personnel and for hospitals, clinics, etc., including the regulation and licensing of providers of health services. For example:

- Department of Health;
- Agencies for the regulation of safety in the workplace.

Excludes organisations primarily engaged in the provision and administration of public health programs which is reported under code 121.

CODE 123 Private health insurance provider

This item is not currently required to be reported by state and territory health authorities.

- Organisations engaged in insurance of health (other than social security funds and other social insurance funds) that provide insurance cover for hospital, medical, dental, pharmaceutical or funeral expenses. This includes organisations primarily engaged in activities involved in or closely related to the management of private health insurance (activities of insurance agents, average and loss adjusters and actuaries.

CODE 188 Main Health Care Service organisation - other

Organisations mainly engaged in providing health care services that are not reported under codes 101 to 123. Includes health or health-related call centres or e-health sites such as Poisons Information Centre and centres that provide information on alcohol and other drugs, mental health or other health issues.

CODE 198 Regional health service (not further defined)

Organisations at an area health service or regional level could be a combination of categories 101 to 188 but which could not be further disaggregated.

CODE 199 State/territory health authority (not further defined)

Organisations at the state or territory health authority level that could be a combination of categories 101 to 188 but which could not be further disaggregated.

Secondary/non-Health Care Service organisation

This item is not currently required to be reported by state and territory health authorities.

CODE 201 Pharmaceutical industry

This item is not currently required to be reported by state and territory health authorities.

Organisations primarily engaged in wholesaling human pharmaceuticals, medicines, cosmetics, perfumes and toiletries. Also included are units mainly engaged in wholesaling veterinary drugs or medicines

Excludes organisations listed under code 119.

CODE 202 University

This item is not currently required to be reported by state and territory health authorities.

Organisations primarily engaged in providing undergraduate or postgraduate teaching but which also undertake health research activities. Also includes organisations primarily engaged in undertaking research in the agricultural, biological, physical or social sciences. Units may undertake the research for themselves or others.

Includes:

- Postgraduate school, university operation
- Research school, university operation
- Specialist institute or college
- Undergraduate school, university operation
- University operation

For reporting purposes includes only the health or health related research component or other health services component of these organisations' activities.

CODE 203 Non-health related insurance

This item is not currently required to be reported by state and territory health authorities.

Units mainly engaged in providing general insurance cover (except life and health insurance).

Includes:

- Motor vehicle third party insurance provision
- Worker's compensation insurance provision

CODE 204 Residential aged care facility

This item is not currently required to be reported by state and territory health authorities.

An organisation comprised of one or more government-funded facilities primarily engaged in providing residential care to aged persons and in receipt of funding under the Aged Care Act and subject to Commonwealth reporting requirements (i.e. report to the System for the payment of Aged Residential Care (SPARC) collection.

Excludes facilities primarily providing services to persons requiring mental health diagnosis and treatment. Also excludes residential care facilities that report under the Commonwealth, State and Territory Disability Agreement where the primary purpose is care for persons with a disability.

CODE 288 Secondary/non-Health Care Service organisation – other

This item is not currently required to be reported by state and territory health authorities.

This item comprises organisations that are not reported under codes 201 to 203 which provide health care as secondary providers or other providers. Included are providers of

occupational health care and home care provided by private households.

Includes:

Occupational health care services not provided in separate health care organisations (all industries);

- Military health services not provided in separate health care organisations
- Prison health services not provided in separate health care organisations
- School health services
- Other providers n.e.c.

Other providers of services which support the health care industry such as laundry or catering services.

Other providers of services unrelated to the health care industry such as the building or automotive industry.

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Reference documents: Organisation for Economic Cooperation and Development 2000. A System of Health Accounts. Version 1.0. Paris: OECD.

Australian Bureau of Statistics 2006. Australian and New Zealand Standard Industry Classification. Cat. no. 1292.0. Canberra: ABS.

RACGP 6 September 2005 <www.racgp.org.au/whatisgeneralpractice>

Data element attributes

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Relational attributes

Related metadata references: Supersedes Health industry relevant organisation—main activity type, code NNN Health, Superseded 01/04/2009

Implementation in Data Set Specifications: Government health expenditure organisation expenditure capital consumption data element cluster Health, Standard 01/04/2009

Government health expenditure organisation expenditure data element cluster Health, Standard 01/04/2009

Government health expenditure organisation expenditure employee related data element cluster Health, Standard 01/04/2009

Government health expenditure organisation expenditure purchase of goods and services data element cluster Health, Standard 01/04/2009

Government health expenditure organisation revenue data element cluster Health, Standard 01/04/2009

Health professionals attended (diabetes mellitus)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—health professionals attended for diabetes mellitus (last 12 months), code N
METeOR identifier:	270287
Registration status:	Health, Standard 01/03/2005
Definition:	The health professionals that a person has attended in the last 12 months in relation to issues arising from diabetes mellitus, as represented by a code.
Data Element Concept:	Person—health professionals attended for diabetes mellitus

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Diabetes educator
2	Dietician
3	Ophthalmologist
4	Optometrist
5	Podiatrist
8	None of the above
9	Not stated/inadequately described

Supplementary values:

Data element attributes

Collection and usage attributes

Guide for use:

Record a code sequentially for each health professional attended.

A person may have attended several health professionals in the last 12 months; therefore more than one code can be recorded sequentially.

Example 1: If a person has attended a diabetes educator and a podiatrist in the last twelve months, the code recorded would be 15.

Example 2: If all have been seen, the code recorded would be 12345.
If the person answers 'NO' to all the health professionals specified, code 8 should be applied.

CODE 9 should only be used in situations where it is not practicable to ask the questions.

Collection methods:

The person should be asked about each type of health professional in successive questions, as follows:

Have you attended any of the following health professionals in relation to diabetes mellitus in the last 12 months?

Diabetes educator ___Yes ___ No

Dietician ___Yes ___ No

Ophthalmologist ___Yes ___ No

Optometrist ___Yes ___ No

Podiatrist ___Yes ___ No

The appropriate code should be recorded for each health professional attended.

Comments:

The health professional occupations are assigned the following codes at the occupation level of the Australian Standard Classification of Occupations, Second Edition, Australian Bureau of Statistics, 1997, Catalogue No. 1220.0

Diabetes educator 2512-13

Dietician 2393-11

Ophthalmologist 2312-19

Optometrist 2384-11

Podiatrist 2388-11

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references: Supersedes Health professionals attended - diabetes mellitus, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.8 KB)

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Heart rate

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—heart rate, total beats per minute N[NN]
METeOR identifier:	285123
Registration status:	Health, Standard 04/06/2004
Definition:	The person's heart rate measured in beats per minute.
Data Element Concept:	Person—heart rate

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3

Supplementary values:

Value	Meaning
997	Cardiac arrest
998	Not recorded
999	Not stated/inadequately described

Unit of measure:	Heart beats per minute

Data element attributes

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Heart rate, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008
	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Heart rhythm type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Electrocardiogram—heart rhythm type, code N[N]
METeOR identifier:	361626
Registration status:	Health, Standard 01/10/2008
Definition:	The type of rhythm associated with the beating of the heart as determined from the electrocardiogram (ECG), as represented by a code.
Data Element Concept:	Electrocardiogram—heart rhythm type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	Sinus rhythm
2	Atrial fibrillation
3	Atrial flutter
4	Second degree heart block
5	Complete heart block
6	Supraventricular tachycardia
7	Idioventricular rhythm
8	Ventricular tachycardia
9	Ventricular fibrillation
10	Paced
11	Other rhythm

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group

Relational attributes

Related metadata references:	Supersedes Person—heart rhythm type, code N[N] Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Electrocardiogram cluster Health, Standard 01/10/2008

Height (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—height (measured), total centimetres NN[N].N
METeOR identifier:	270361
Registration status:	Health, Standard 01/03/2005
Definition:	The height of a person measured in centimetres.
Context:	Public health and health care
Data Element Concept:	Person—height

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NN[N].N
Maximum character length:	4

Supplementary values:

Value	Meaning
999.9	Not measured

Unit of measure: Centimetre (cm)

Data element attributes

Collection and usage attributes

Guide for use:

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

Measurements of height should be assessed in relation to children and adolescents' age and pubertal status.

Collection methods:

The measurement protocol described below are 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).*

Measurement protocol:

Height measurements can be based on recumbent length or standing height. In general, length measurements are recommended for children under 2 years of age and height measurements for others.

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.

Adults and children who can stand:

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.

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 & 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.

Infants:

For the measurement of supine length of children up to and including 2 years of age, two observers are required. One observer positions the head correctly while the other ensures the remaining position is correct and brings the measuring board in contact with the feet. The subject lies in a supine position on a recumbent length table or measuring board. The crown of the head must touch the stationary, vertical headboard. The subject's head is held with the line of vision aligned perpendicular to the plane of the measuring surface. The shoulders and buttocks must be flat against the table top, with the shoulders and hips aligned

at right angles to the long axis of the body. The legs must be extended at the hips and knees and lie flat against the table top and the arms rest against the sides of the trunk. The measurer must ensure that the legs remain flat on the table and must shift the movable board against the heels. In infants care has to be taken to extend the legs gently. In some older children two observers may also be required.

In general, length or height is measured and reported to the nearest 0.1 cm. For any child, the length measurement is approximately 0.5 - 1.5 cm greater than the height measurement. It is therefore recommended that when a length measurement is applied to a height-based reference for children over 24 months of age (or over 85 cm if age is not known), 1.0 cm be subtracted before the length measurement is compared with the reference. It is also recommended that as a matter of procedure and data recording accuracy, the date be recorded when the change is made from supine to standing height measure.

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.

Comments:

This metadata item applies to persons of all ages. 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.

Metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

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. However 5-year age groups are not generally suitable for children and adolescents. 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, women, children and adolescents although the range will depend on the population:

Height

70 cm = Height

75 cm = Height

... in 5 cm categories

185 cm = Height

Height => 190 cm

Relational attributes

Related metadata references:

Supersedes Height - measured, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (28.7 KB)

Is used in the formation of Adult—body mass index (measured), ratio NN[N].N[N] Health, Standard 01/03/2005

Is used in the formation of Child—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005

Is used in the formation of Child—body mass index (measured), ratio NN[N].N[N] Health, Standard 01/03/2005

Is used in the formation of Adult—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Height (self-reported)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—height (self-reported), total centimetres NN[N]
METeOR identifier:	270365
Registration status:	Health, Standard 01/03/2005
Definition:	A person's self-reported height, measured in centimetres.
Data Element Concept:	Person—height

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NN[N]
Maximum character length:	3

Supplementary values:

Value	Meaning
888	Unknown
999	Not stated/inadequately described

Unit of measure: Centimetre (cm)

Data element attributes

Collection and usage attributes

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 Australian Bureau of Statistics 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 & Berry 1994):

NNN.x where x

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.

Comments:

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

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.

Metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

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.

Height <140 cm

140 cm = Height < 145 cm

145 cm = Height < 150 cm

... in 5 cm categories

185 cm = Height < 190 cm

Height => 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.

*Note: SEM is the standard error of measurement.

Relational attributes

Related metadata references:	Supersedes Height - self-reported, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.0 KB)
	Is used in the formation of Child—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005
	Is used in the formation of Adult—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008
	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Hip circumference (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—hip circumference (measured), total centimetres NN[N].N
METeOR identifier:	270366
Registration status:	Health, Standard 01/03/2005
Definition:	An adult's hip circumference at the level of maximum posterior extension of the buttocks measured in centimetres.
Data Element Concept:	Person—hip circumference

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NN[N].N
Maximum character length:	4

Supplementary values:

Value	Meaning
999.9	Not measured

Unit of measure: Centimetre (cm)

Data element attributes

Collection and usage attributes

Guide for use: As there are no cut-off points for waist-to-hip ratio for children and adolescents, it is not necessary to collect this metadata item for those aged under 18 years.

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

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 (

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.

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 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.

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.

Comments:

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

Its main use is to enable the calculation of adult waist-to-hip ratio which requires the measurement of hip circumference and waist circumference.

More recently it has emerged that waist circumference alone, or in combination with other metabolic measures, is a better indicator of risk and reduces the errors in waist-to-hip ratio measurements.

Waist-to-hip ratio is therefore no longer a commonly used measure.

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.

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. However 5-year age groups are not generally suitable for children and adolescents. 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 hip circumference data in categories. It is recommended that 5 cm groupings be used for this purpose. Hip circumference data should not be rounded before categorisation.

Relational attributes

Related metadata references:

Supersedes Hip circumference - measured, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (23.1 KB)

Is used in the formation of Adult—waist-to-hip ratio, N.NN Health, Standard 01/03/2005

Histopathological grade

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—histopathological grade, code N
METeOR identifier:	370019
Registration status:	Health, Standard 06/03/2009
Definition:	The histopathological grade or differentiation describes how much the tumour resembles the normal tissue from which it arose, as represented by a code. For lymphohaematopoietic neoplasms (leukaemias and lymphomas) this data element is used to denote cell lineage.
Data Element Concept:	Person with cancer—histopathological grade

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Grade 1: Low grade; well differentiated, differentiated, NOS
2	Grade 2: Intermediate grade, moderately differentiated, moderately well differentiated, intermediate differentiation
3	Grade 3: High grade, poorly differentiated
4	Grade 4: Undifferentiated, anaplastic
5	T-cell: T-cell
6	B-cell: B-cell, Pre-B, B-Precursor
7	Null-cell: Null cell, Non T- non B
8	NK-cell: Natural killer cell

Supplementary values:

Value	Meaning
9	Grade/differentiation unknown: Grade/cell type not determined, not stated or not applicable

Data element attributes

Collection and usage attributes

Guide for use:	Only one code can be recorded. When more than one grade is documented for the primary tumour within the same specimen report, use the highest grade. For example, if grade 2-3 is documented, record the grade as 3. If the grades differ on multiple pathology reports for the same

tumour, use the value from the larger specimen (for example, the grade from a surgical excision specimen would be used over the grade from a specimen from a diagnostic biopsy).

Breast cancer coding rules:

Use the Nottingham grade (Elston-Ellis modification of Bloom-Richardson grading system). This classification only uses grades 1-3, 9.

For an invasive tumour with an in situ component, record the grade for the invasive component only. If the grade of the invasive component is not reported, record the grade as unknown.

Collection methods:

Cancer registry use:

Collection of this data item should only be from notification and pathology reports relating to initial diagnosis and not for recurrent or metastatic disease.

Source and reference attributes

Origin:

World Health Organisation

Commission on Cancer American College of Surgeons

Reference documents:

World Health Organisation International Classification of Diseases Oncology, Third edition (ICD-O-3) (2000)

Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Johnson CH, Adamo M (eds.), SEER Program Coding and Staging Manual 2007. National Cancer Institute, NIH Publication number 07-5581, Bethesda, MD 2007.

Relational attributes

Related metadata references:

Supersedes Person with cancer—histopathological grade, code N Health, Superseded 06/03/2009

Implementation in Data Set Specifications:

Breast cancer (Cancer registries) DSS Health, Standard 06/03/2009

Cancer (clinical) DSS Health, Superseded 22/12/2009

Cancer (clinical) DSS Health, Standard 22/12/2009

Hospital insurance status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—hospital insurance status, code N
METeOR identifier:	270253
Registration status:	Health, Standard 01/03/2005
Definition:	Hospital insurance as represented by a code under one of the following categories: • Registered insurance - hospital insurance with a health insurance fund registered under the National Health Act 1953 (Cwlth) • 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.
Data Element Concept:	Patient—hospital insurance status

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Hospital insurance
	2	No hospital insurance
Supplementary values:	9	Unknown

Data element attributes

Collection and usage attributes

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 metadata item is to determine whether the patient has hospital insurance, not their method of payment for the episode of care.
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.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Hospital insurance status, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.6 KB)

Implementation in Data Set Specifications:

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Hours on-call (not worked) by medical practitioner

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Medical practitioner—hours on-call, total NNN
METeOR identifier:	270138
Registration status:	Health, Standard 01/03/2005
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.
Data Element Concept:	Medical practitioner—hours on-call

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	String
Format:	NNN
Maximum character length:	3

Supplementary values:

Value	Meaning
999	Not stated/inadequately described

Unit of measure: Hour (h)

Collection and usage attributes

Guide for use: Total hours expressed as 000, 001 etc.

Data element attributes

Collection and usage attributes

Guide for use: This metadata item relates to each position (job) held by a medical practitioner.

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.

Relational attributes

Related metadata references: Supersedes Hours on-call (not worked) by medical practitioner, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.5 KB)

Implementation in Data Set Specifications: Health labour force NMDS Health, Standard 01/03/2005

Implementation start date: 01/07/2005

Hours worked in health profession—clinical

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—hours worked in clinical role, total hours NNN
METeOR identifier:	375301
Registration status:	Health, Standard 10/12/2009
Definition:	The total number of hours a health professional worked in their registered profession undertaking diagnosis, care and treatment of patients.
Context:	Health labour force
Data Element Concept:	Registered health professional—hours worked in clinical role

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	String	
Format:	NNN	
Maximum character length:	3	
Supplementary values:	Value	Meaning
	999	Not stated/inadequately described
Unit of measure:	Hour (h)	

Collection and usage attributes

Guide for use:	Total hours expressed as 000, 001 etc.

Data element attributes

Collection and usage attributes

Guide for use:	Total hours worked are for both employed and self-employed health professionals. Total hours worked in clinical role: • includes travel to home visits or calls out; • excludes other time travelling between work locations; and • excludes unpaid professional and/or voluntary activities. Registered health professionals on leave at the time of registration are asked to report their usual hours worked.
Collection methods:	Total hours worked refers to hours worked in the week before registration.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

Supersedes Medical practitioner—hours worked (in direct patient care), total NNN Health, Superseded 10/12/2009

See also Registered health professional—hours worked in public sector, total hours NNN Health, Standard 10/12/2009

See also Registered health professional—hours worked in private sector, total hours NNN Health, Standard 10/12/2009

See also Registered health professional—hours worked in health profession, total hours NNN Health, Standard 10/12/2009

See also Registered health professional—hours worked in non-clinical role Health, Standard 10/12/2009

See also Work setting hours cluster Health, Standard 10/12/2009

See also Registered health professional—hours worked in non-clinical role, total hours NNN Health, Standard 10/12/2009

Implementation in Data Set Specifications:

Registered chiropractic labour force DSS Health, Standard 10/12/2009

Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009

Registered medical professional labour force DSS Health, Standard 10/12/2009

Registered midwifery labour force DSS Health, Standard 10/12/2009

Registered nursing professional labour force DSS Health, Standard 10/12/2009

Registered optometry labour force DSS Health, Standard 10/12/2009

Registered osteopathy labour force DSS Health, Standard 10/12/2009

Registered pharmacy labour force DSS Health, Standard 10/12/2009

Registered physiotherapy labour force DSS Health, Standard 10/12/2009

Registered podiatry labour force DSS Health, Standard 10/12/2009

Registered psychology labour force DSS Health, Standard 10/12/2009

Hours worked in health profession—non-clinical

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—hours worked in non-clinical role, total hours NNN
METeOR identifier:	375305
Registration status:	Health, Standard 10/12/2009
Definition:	The total number of hours a health professional worked in a non-clinical role in their registered profession.
Context:	Health labour force
Data Element Concept:	Registered health professional—hours worked in non-clinical role

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	String	
Format:	NNN	
Maximum character length:	3	
Supplementary values:	Value	Meaning
	999	Not stated/inadequately described
Unit of measure:	Hour (h)	

Collection and usage attributes

Guide for use:	Total hours expressed as 000, 001 etc.

Data element attributes

Collection and usage attributes

Guide for use:

Total hours worked are for both employed and self-employed health professionals.

Total hours worked in non-clinical role includes:

- time spent as an administrator, teacher/educator, researcher or other non-clinician role in the profession; and
- travel to home visits or calls out.

Total hours worked in non-clinical role excludes:

- time spent in the diagnosis, care and treatment of patients;
- time travelling between work locations; and
- unpaid professional and/or voluntary activities.

Registered health professionals on leave at the time of registration are asked to report their usual hours worked.

Collection methods: Total hours worked refers to hours worked in the week before registration.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

See also Registered health professional—hours worked in public sector, total hours NNN Health, Standard 10/12/2009

See also Registered health professional—hours worked in private sector, total hours NNN Health, Standard 10/12/2009

See also Registered health professional—hours worked in health profession, total hours NNN Health, Standard 10/12/2009

See also Registered health professional—hours worked in clinical role, total hours NNN Health, Standard 10/12/2009

See also Work setting hours cluster Health, Standard 10/12/2009

Implementation in Data Set Specifications:

Registered chiropractic labour force DSS Health, Standard 10/12/2009

Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009

Registered medical professional labour force DSS Health, Standard 10/12/2009

Registered midwifery labour force DSS Health, Standard 10/12/2009

Registered nursing professional labour force DSS Health, Standard 10/12/2009

Registered optometry labour force DSS Health, Standard 10/12/2009

Registered osteopathy labour force DSS Health, Standard 10/12/2009

Registered pharmacy labour force DSS Health, Standard 10/12/2009

Registered physiotherapy labour force DSS Health, Standard 10/12/2009

Registered podiatry labour force DSS Health, Standard 10/12/2009

Registered psychology labour force DSS Health, Standard 10/12/2009

Hours worked in health profession—private sector

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—hours worked in private sector, total hours NNN
METeOR identifier:	382906
Registration status:	Health, Standard 10/12/2009
Definition:	The total number of hours a health professional worked in non-government sector employment in their registered profession.
Context:	Health labour force
Data Element Concept:	Registered health professional—hours worked in private sector

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	String	
Format:	NNN	
Maximum character length:	3	
Supplementary values:	Value	Meaning
	999	Not stated/inadequately described
Unit of measure:	Hour (h)	

Collection and usage attributes

Guide for use:	Total hours expressed as 000, 001 etc.

Data element attributes

Collection and usage attributes

Guide for use:

Total hours worked are for both employed and self-employed health professionals.

Total hours worked in private sector:

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

Registered health professionals on leave at the time of registration are asked to report their usual hours worked.

Private sector employment is employment by an establishment that may receive some government funding but is run by the non-government sector. Private sector establishments are not controlled by government, are directed by a group of officers, an executive committee or a similar body elected by a majority of members, and may be an income tax exempt charity.

Collection methods: Total hours worked refers to hours worked in the week before registration.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

See also Registered health professional—hours worked in health profession, total hours NNN Health, Standard 10/12/2009

See also Work setting hours cluster Health, Standard 10/12/2009

See also Registered health professional—hours worked in non-clinical role, total hours NNN Health, Standard 10/12/2009

See also Registered health professional—hours worked in public sector, total hours NNN Health, Standard 10/12/2009

See also Registered health professional—hours worked in clinical role, total hours NNN Health, Standard 10/12/2009

Implementation in Data Set Specifications:

Registered chiropractic labour force DSS Health, Standard 10/12/2009

Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009

Registered medical professional labour force DSS Health, Standard 10/12/2009

Registered midwifery labour force DSS Health, Standard 10/12/2009

Registered nursing professional labour force DSS Health, Standard 10/12/2009

Registered optometry labour force DSS Health, Standard 10/12/2009

Registered osteopathy labour force DSS Health, Standard 10/12/2009

Registered pharmacy labour force DSS Health, Standard 10/12/2009

Registered physiotherapy labour force DSS Health, Standard 10/12/2009

Registered podiatry labour force DSS Health, Standard 10/12/2009

Registered psychology labour force DSS Health, Standard 10/12/2009

Hours worked in health profession—public sector

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—hours worked in public sector, total hours NNN
METeOR identifier:	382908
Registration status:	Health, Standard 10/12/2009
Definition:	The total number of hours a health professional worked in government sector employment in their registered profession.
Context:	Health labour force
Data Element Concept:	Registered health professional—hours worked in public sector

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	String	
Format:	NNN	
Maximum character length:	3	
Supplementary values:	Value	Meaning
	999	Not stated/inadequately described
Unit of measure:	Hour (h)	

Collection and usage attributes

Guide for use:	Total hours expressed as 000, 001 etc.

Data element attributes

Collection and usage attributes

Guide for use:

Total hours worked are for both employed and self-employed health professionals.

Total hours worked in public sector:

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

Registered health professionals on leave at the time of registration are asked to report their usual hours worked.

Public sector employment is employment with an establishment run by the government sector. A public sector establishment:

- operates from the public accounts of a Commonwealth, state or territory government or is part of the executive, judicial or legislative arms of government,
- is part of the general government sector or is controlled by some part of the general government sector,

- provides government services free of charge or at nominal prices, and
- is financed mainly from taxation.

Collection methods: Total hours worked refers to hours worked in the week before registration.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

See also Registered health professional—hours worked in health profession, total hours NNN Health, Standard 10/12/2009

See also Work setting hours cluster Health, Standard 10/12/2009

See also Registered health professional—hours worked in non-clinical role, total hours NNN Health, Standard 10/12/2009

See also Registered health professional—hours worked in private sector, total hours NNN Health, Standard 10/12/2009

See also Registered health professional—hours worked in clinical role, total hours NNN Health, Standard 10/12/2009

Implementation in Data Set Specifications:

Registered chiropractic labour force DSS Health, Standard 10/12/2009

Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009

Registered medical professional labour force DSS Health, Standard 10/12/2009

Registered midwifery labour force DSS Health, Standard 10/12/2009

Registered nursing professional labour force DSS Health, Standard 10/12/2009

Registered optometry labour force DSS Health, Standard 10/12/2009

Registered osteopathy labour force DSS Health, Standard 10/12/2009

Registered pharmacy labour force DSS Health, Standard 10/12/2009

Registered physiotherapy labour force DSS Health, Standard 10/12/2009

Registered podiatry labour force DSS Health, Standard 10/12/2009

Registered psychology labour force DSS Health, Standard 10/12/2009

Hours worked in health profession—total

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—hours worked in health profession, total hours NNN
METeOR identifier:	375286
Registration status:	Health, Standard 10/12/2009
Definition:	The total number of hours a health professional worked in their registered profession.
Context:	Health labour force
Data Element Concept:	Registered health professional—hours worked in health profession

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	String
Format:	NNN
Maximum character length:	3

Supplementary values:

Value	Meaning
999	Not stated/inadequately described

Unit of measure:	Hour (h)

Collection and usage attributes

Guide for use:	Total hours expressed as 000, 001 etc.

Data element attributes

Collection and usage attributes

Guide for use:

Total hours worked are for both employed and self-employed health professionals.

Total hours worked in health profession:

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

Registered health professionals on leave at the time of registration are asked to report their usual hours worked.

Collection methods:

Total hours worked refers to hours worked in the week before registration.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

Supersedes Medical practitioner—hours worked, total NNN Health, Superseded 10/12/2009

See also Registered health professional—hours worked in clinical role, total hours NNN Health, Standard 10/12/2009

See also Registered health professional—hours worked in non-clinical role, total hours NNN Health, Standard 10/12/2009

See also Registered health professional—hours worked in private sector, total hours NNN Health, Standard 10/12/2009

See also Registered health professional—hours worked in public sector, total hours NNN Health, Standard 10/12/2009

Supersedes Health professional—hours worked (in all jobs), total NNN Health, Superseded 10/12/2009

Implementation in Data Set Specifications:

Main job of registered chiropractor cluster Health, Standard 10/12/2009

Main job of registered dental and allied dental health professional cluster Health, Standard 10/12/2009

Main job of registered medical professional cluster Health, Standard 10/12/2009

Main job of registered midwife cluster Health, Standard 10/12/2009

Main job of registered nursing professional cluster Health, Standard 10/12/2009

Main job of registered optometrist cluster Health, Standard 10/12/2009

Main job of registered osteopath cluster Health, Standard 10/12/2009

Main job of registered pharmacist cluster Health, Standard 10/12/2009

Main job of registered physiotherapist cluster Health, Standard 10/12/2009

Main job of registered podiatrist cluster Health, Standard 10/12/2009

Main job of registered psychologist cluster Health, Standard 10/12/2009

Registered chiropractic labour force DSS Health, Standard 10/12/2009

Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009

Registered medical professional labour force DSS Health, Standard 10/12/2009

Registered midwifery labour force DSS Health, Standard 10/12/2009

Registered nursing professional labour force DSS Health, Standard 10/12/2009

Registered optometry labour force DSS Health, Standard 10/12/2009

Registered osteopathy labour force DSS Health, Standard 10/12/2009

Registered pharmacy labour force DSS Health, Standard 10/12/2009

Registered physiotherapy labour force DSS Health, Standard 10/12/2009

Registered podiatry labour force DSS Health, Standard 10/12/2009

Registered psychology labour force DSS Health, Standard 10/12/2009

Second job of registered chiropractor cluster Health, Standard 10/12/2009

Second job of registered dental and allied dental health professional cluster Health, Standard 10/12/2009

Second job of registered medical professional cluster Health, Standard 10/12/2009

Second job of registered midwife cluster Health, Standard 10/12/2009

Second job of registered nursing professional cluster Health, Standard 10/12/2009

Second job of registered optometrist cluster Health, Standard 10/12/2009

Second job of registered osteopath cluster Health, Standard 10/12/2009

Second job of registered pharmacist cluster Health, Standard 10/12/2009

Second job of registered physiotherapist cluster Health, Standard 10/12/2009

Second job of registered podiatrist cluster Health, Standard 10/12/2009

Second job of registered psychologist cluster Health, Standard 10/12/2009

Work setting hours cluster Health, Standard 10/12/2009

House/property number (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—house/property identifier, text [X(12)]
Synonymous names:	Australian street number
METeOR identifier:	270030
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	The identifier of a house or property where a person resides, as represented by text.
Data Element Concept:	Person (address)—house/property identifier

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(12)]
Maximum character length:	12

Data element attributes

Collection and usage attributes

Guide for use:

Generally, only one house/property number is used. However, if the house/property number includes a number range, the range of applicable numbers should be included, separated by a hyphen (-), with no spaces between numerals, i.e. 17-19

- House/property number 1 - refers to physical House/property number and for ranges is the starting number (5 numeric characters)
- House/property number Suffix 1 - a single character identifying the House/property number suffix (1 alphanumeric character)
- House/property number 2 - refers to a physical House/property number and for ranges is the finishing number (5 numeric characters)
- House/property number suffix 2 - a single character identifying the House/property number suffix (1 alphanumeric character) with no space between the numeric and the alpha characters.

For example; '401A 403B'

'401' is House/property number first in range

'A' is the House/Property suffix 1

'403' is House/property number last in range

'B' is House/Property suffix 2

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Australia Post Address Presentation Standard
Reference documents:	AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

Related metadata references:	Supersedes House/property number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.6 KB)
	Is used in the formation of Person (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005
	Is used in the formation of Person (address)—health address line, text [X(180)] Health, Superseded 04/05/2005
Implementation in Data Set Specifications:	Health care client identification DSS Health, Superseded 03/12/2008
	Health care client identification DSS Health, Standard 03/12/2008
	Health care provider identification DSS Health, Superseded 04/07/2007
	Health care provider identification DSS Health, Superseded 03/12/2008
	Health care provider identification DSS Health, Standard 03/12/2008

House/property number (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—house/property identifier, text [X(12)]
METeOR identifier:	290241
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The unique identifier of a house or property where an organisation is located.
Data Element Concept:	Service provider organisation (address)—house/property identifier

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(12)]
Maximum character length:	12

Data element attributes

Collection and usage attributes

Guide for use:

Generally, only one house/property number is used. However, if the house/property number includes a number range, the range of applicable numbers should be included, separated by a hyphen (-), with no spaces between numerals, i.e. 17-19

- House/property number 1 - refers to physical House/property number and for ranges is the starting number (5 numeric characters)
- House/property number Suffix 1 - a single character identifying the House/property number suffix (1 alphanumeric character)
- House/property number 2 - refers to a physical House/property number and for ranges is the finishing number (5 numeric characters)
- House/property number suffix 2 - a single character identifying the House/property number suffix (1 alphanumeric character) with no space between the numeric and the alpha characters.

For example; '401A 403B'

'401' is House/property number first in range

'A' is the House/Property suffix 1

'403' is House/property number last in range

'B' is House/Property suffix 2

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Australia Post Address Presentation Standard

Relational attributes

Related metadata references: Is used in the formation of Service provider organisation (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Implementation in Data Set Specifications: Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Superseded 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Household annual gross income range

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Household—gross income (annual), dollar range code N
METeOR identifier:	290737
Registration status:	Health, Standard 04/05/2005
Definition:	The value of gross annual income from all sources (before deductions for income tax, superannuation, etc.) for all household members as represented by a dollar range code.
Context:	Gross household income ranges are used as an indicator of the economic status of the household.
Data Element Concept:	Household—gross income

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Less than $ 20,000
2	$ 20,001-$ 30,000
3	$ 30,001-$ 50,000
4	$ 50,001 - $ 100,000
5	More than $ 100,000

Supplementary values:

6	Don't know/not sure
7	Not stated

Data element attributes

Collection and usage attributes

Guide for use: The main components of gross income are:

- current usual wages and salary;
- income derived from self-employment;
- government pensions, benefits and allowances; and
- other income comprising investments (including interest, dividends, royalties and rent) and other regular income (including superannuation, private scholarships received in cash, workers' compensation, accident compensation, maintenance or alimony, and any other allowances regularly received).

Gross income is regarded as all receipts which are received regularly and are of a recurring nature. Certain receipts such as lump sum receipts, windfall gains and withdrawals from savings are not considered to conform to these criteria and are not included as income.

Please note that this data element is not consistent with the ABS standards for cash income.

Source and reference attributes

Submitting organisation: National Public Health Information Working Group

Reference documents: Refer to the ABS website Statistical Standards/Standards for Social, Labour and Demographic Variables/Cash Income Variables:

1200.0 - Standards for Social, Labour and Demographic Variables, 1999

Relational attributes

Implementation in Data Set Specifications: Computer Assisted Telephone Interview demographic module DSS Health, Superseded 03/12/2008

Computer Assisted Telephone Interview demographic module DSS Health, Standard 03/12/2008

Household annual gross income range ($10,000 range)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Household—gross income (annual), ten thousand dollar range code N[N]
METeOR identifier:	290742
Registration status:	Health, Standard 04/05/2005
Definition:	The value of gross annual income from all sources (before deductions for income tax, superannuation, etc.) for all household members as represented by a ten thousand dollar range code.
Context:	Gross household income ($10,000 ranges) is used as an indicator of the economic status of the household.
Data Element Concept:	Household—gross income

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	Less than $ 10,000
2	$ 10,000 - $ 20,000
3	$ 20,001 - $ 30,000
4	$ 30,001 - $ 40,000
5	$ 40,001 - $ 50,000
6	$ 50,001 - $ 60,000
7	$ 60,001 - $ 70,000
8	$ 70,001 - $ 80,000
9	$ 80,001 - $ 90,000
10	$ 90,001 - $ 100,000
11	More than $ 100,000

Supplementary values:

12	Don't know / not sure
13	Not stated

Data element attributes

Collection and usage attributes

Guide for use: The main components of gross income are:

- current usual wages and salary;

- income derived from self-employment;
- government pensions, benefits and allowances; and
- other income comprising investments (including interest, dividends, royalties and rent) and other regular income (including superannuation, private scholarships received in cash, workers' compensation, accident compensation, maintenance or alimony, and any other allowances regularly received).

Gross income is regarded as all receipts which are received regularly and are of a recurring nature. Certain receipts such as lump sum receipts, windfall gains and withdrawals from savings are not considered to conform to these criteria and are not included as income.

Please note that this data element is not consistent with the ABS standards for cash income.

Refer to the ABS website Standards for Social, Labour and Demographic Variables/Cash Income Variables:
1200.0 - Standards for Social, Labour and Demographic Variables, 1999

Source and reference attributes

Submitting organisation: National Public Health Information Working Group

Relational attributes

Implementation in Data Set Specifications:

Computer Assisted Telephone Interview demographic module DSS Health, Superseded 03/12/2008

Computer Assisted Telephone Interview demographic module DSS Health, Standard 03/12/2008

Human epidermal growth factor receptor-2 test result

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—human epidermal growth factor receptor-2 test result, code N
Synonymous names:	HER2 test result
METeOR identifier:	370572
Registration status:	Health, Standard 06/03/2009
Definition:	The result of a person's human epidermal growth factor receptor-2 (HER2) test, as represented by a code.
Data Element Concept:	Person with cancer—human epidermal growth factor receptor-2 test result

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values: / *Supplementary values:*

Value	Meaning
1	Positive
2	Negative
3	Equivocal
7	Unknown (test results not available)
8	Not applicable (test not done)

Collection and usage attributes

Guide for use:

Record the reported conclusion of the HER2.

If no conclusion is reported use the following guidelines (from the National Breast and Ovarian Cancer Centre and Australian Cancer Network's pathology reporting guide (3rd ed.) for breast cancer):

CODE 1 Positive

- **For in situ hybridisation:**
  Result is more than 6 copies of the HER2 gene per nucleus OR a ratio of HER2 gene signals to chromosome 17 signals of more than 2.2.
- **For Immunochemistry:**
  Result is described as 3+ or +++ OR >30% of cancer cells show strong complete membrane staining without cytoplasmic staining and without staining of normal tissue.

CODE 2 Negative

- **For in situ hybridisation:**
  Result is less than 4 copies of the HER2 gene per nucleus OR a ratio of HER2 gene signals to chromosome 17 signals of less than 1.8.
- **For Immunochemistry:**
  Result described as 0, 1+ or + OR <10% of cancer cells show staining.

CODE 3 Equivocal

- **For in situ hybridisation:**
  Result is an average of between 4 and 6 HER2 gene copies per nucleus with a single probe OR a ratio of HER2 gene signals to chromosome 17 signals in the range of 1.8-2.2.
- **For Immunochemistry:**
  Result described as 2+ or ++ OR <10% of cancer cells show strong complete membrane staining (rare) OR 10-30% of cancer cells show weak to moderate complete membrane staining OR Strong cytoplasmic staining is present, making assessment of membrane staining difficult.

Supplementary codes

CODE 7 Unknown (test results not available)

Use this code when the test has been performed but the results are not yet available for analysis.

CODE 8 Not applicable (test not done)

This code is used as a validation measure, to show that the reason for the lack of results is due to the test not being performed.

Data element attributes

Collection and usage attributes

Collection methods:

For cancer registries, collection of this data item should only be from notification and pathology reports relating to initial diagnosis and not for recurrent or subsequent metastatic disease.

Where different values are available from multiple specimens, the appropriate values to enter are selected according to the following hierarchy of rules:

When multiple HER2 values are available, the value established by the most accurate test is used as per the hierarchy: FISH > CISH/SISH > IHC. (See Person with cancer—HER2 test type, code N) If the HER2 values differ on multiple pathology reports for the same tumour, use the value from the larger specimen.

For multifocal tumours, use the HER2 value from the largest focus or from a metastatic deposit; e.g. Lymph node metastasis. A smaller focus that is HER2 positive may in fact be the source of a metastasis and in this setting the patient would derive benefit from the therapy offered as a result of HER2 positive status.

Comments:

Human epidermal growth factor receptor-2 (HER2) promotes the growth of cancer cells. HER2 is also known as c-erB-2 and Her2/neu. Tumours that are HER2-positive tend to grow more quickly than other types of cancer. HER2 status is an important prognostic marker and predicts the response to several therapies.

Source and reference attributes

Origin:	National Breast and Ovarian Cancer Centre (NBOCC) Australasian Association of Cancer Registries (AACR) Australian Institute of Health and Welfare (AIHW)
Reference documents:	National Breast and Ovarian Cancer Centre and Australian Cancer Network. The Pathology reporting of breast cancer. A guide for pathologists, surgeons, radiologists and oncologists (3rd edition). National Breast and Ovarian Cancer Centre, Surry Hills, NSW, 2008.

Relational attributes

Implementation in Data Set Specifications:	Breast cancer (Cancer registries) DSS Health, Standard 06/03/2009

Human epidermal growth factor receptor-2 test type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—human epidermal growth factor receptor-2 test type, code N
Synonymous names:	HER2 test type
METeOR identifier:	370607
Registration status:	Health, Standard 06/03/2009
Definition:	The type of test used to determine the results of human epidermal growth factor receptor-2 (HER2) at the time of diagnosis of the primary tumour, as represented by a code.
Data Element Concept:	Person with cancer—human epidermal growth factor receptor-2 test type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Fluorescence in situ hybridisation (FISH)
2	Brightfield in situ hybridisation
3	Immunochemistry (IHC)
8	Other

Supplementary values:

Value	Meaning
9	Test type not stated or unknown

Collection and usage attributes

Guide for use: CODE 2 Brightfield in situ hybridisation

Includes Chromogenic in situ hybridisation (CISH) and Silver in situ hybridisation (SISH).

Data element attributes

Collection and usage attributes

Guide for use:	Record the test type corresponding to the test result recorded in 'Person with Cancer - human epidermal growth factor receptor-2 test result'.
Comments:	Immunochemistry (IHC) measures how much HER2 protein is present in the tumour sample. Fluorescence in situ hybridisation (FISH), chromogenic in situ hybridisation (CISH) and silver in situ hybridisation (SISH) measure the amount of amplification of the gene responsible for HER2. The type of HER2 test used to determine HER2 status affects the accuracy of the information.

Source and reference attributes

Origin:	National Breast and Ovarian Cancer Centre (NBOCC) Australasian Association of Cancer Registries (AACR) Australian Institute of Health and Welfare (AIHW)

Relational attributes

Implementation in Data Set Specifications:	Breast cancer (Cancer registries) DSS Health, Standard 06/03/2009

Hypertension—treatment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—hypertension treatment with antihypertensive medication indicator (current), code N
METeOR identifier:	302442
Registration status:	Health, Standard 21/09/2005
Definition:	Whether a person is currently being treated for hypertension (high blood pressure) using antihypertensive medication, as represented by a code.
Data Element Concept:	Person—hypertension treatment with antihypertensive medication indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described
	This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes
	Record if a person is currently being treated for hypertension using antihypertensive medication.
	CODE 2 No
	Record if a person is not currently being treated for hypertension using antihypertensive medication.
Collection methods:	Ask the individual if he/she is currently treated with anti-hypertensive medications. Alternatively obtain the relevant information from appropriate documentation.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.
Reference documents:	Pahor M, Psaty BM, Furberg CD. Treatment of hypertensive patients with diabetes. Lancet 1998; 351:689-90. Tight blood pressure control and risk of macrovascular and microvascular complications in type 2 diabetes: UKPDS 38. UK Prospective Diabetes Study Group [erratum appears in Br Med J 1999; 318:29]. Br Med J 1998; 317:703-13. Grossman E, Messerli FH, Goldbourt U, Curb JD, Pressel SL, Cutler JA, Savage PJ, Applegate WB, Black H, et al. Effect of diuretic-based antihypertensive treatment on cardiovascular disease risk in older diabetic patients with isolated systolic hypertension. Systolic Hypertension in the Elderly Program Cooperative Research Group. JAMA 1996; 276:1886-92. Hypertension in diabetes [Australian Prescriber Feb 2002]. American Journal of Preventive Medicine 2002;21.

Relational attributes

Related metadata references:	Supersedes Person—hypertension treatment status (antihypertensive medication), code N Health, Superseded 21/09/2005
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008 Diabetes (clinical) DSS Health, Standard 21/09/2005

Hypoglycaemia—severe

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—severe hypoglycaemia indicator, code N
METeOR identifier:	302825
Registration status:	Health, Standard 21/09/2005
Definition:	Whether a person has had **severe hypoglycaemia**, as represented by a code.
Data Element Concept:	Person—severe hypoglycaemia indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes: Record if the person has a history of severe hypoglycaemia. CODE 2 No: Record if the person has no history of severe hypoglycaemia.
Collection methods:	Ask the individual if he/she has had a severe hypoglycaemia requiring assistance. Alternatively obtain the relevant information from appropriate documentation.
Comments:	The medications used in the treatment of diabetes may cause the blood glucose value to fall below the normal range and this is called hypoglycaemia.

Source and reference attributes

Submitting organisation:	National diabetes data working group

Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.
Reference documents:	Definition corresponds with the Diabetes Control and Complications Trial (DCCT): DCCT New England Journal of Medicine, 329(14), September 30, 1993. Report of the Health Care Committee Expert Panel on Diabetes; Commonwealth of Australia 1991; ISBN 0644143207.

Relational attributes

Related metadata references:	Supersedes Person—severe hypoglycaemia history, status code N Health, Superseded 21/09/2005
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Standard 21/09/2005

Impairment of body function

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—extent of impairment of body function, code (ICF 2001) N
METeOR identifier:	320138
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	A person's degree of impairment in a specified body function, as represented by a code.
Context:	Human functioning and disability
Data Element Concept:	Person—extent of impairment of body function

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Functioning, Disability and Health 2001
Representation class:	Code
Data type:	String
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
0	No impairment
1	Mild impairment
2	Moderate impairment
3	Severe impairment
4	Complete impairment

Supplementary values:

Value	Meaning
8	Not specified
9	Not applicable

Collection and usage attributes

Guide for use:

This metadata item contributes to the definition of the concept '**Disability**' and gives an indication of the experience of disability for a person.

Impairments of body structure or body function are problems in body structure or function such as a loss or significant departure from population standards or averages.

CODE 0 No impairment

Used when there is no significant variation from accepted population standards in the biomedical status of the body structure or its functions [0-4%].

CODE 1 Mild impairment

Used when there is a slight or low variation from accepted population standards in the biomedical status of the body structure or its functions [5-24%].

CODE 2 Moderate impairment

Used when there is a medium (significant but not severe) variation from accepted population standards in the biomedical status of the body structure or its functions [25-49%].

CODE 3 Severe impairment

Used when there is an extreme variation from accepted population standards in the biomedical status of the body structure or its functions [50-95%].

CODE 4 Complete impairment

Used when there is a total variation from accepted population standards in the biomedical status of the body structure or its functions [96-100%].

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin: World Health Organization (WHO) 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents: Further information on the ICF including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website http://www.who.int/classifications/icf/en/
- Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.cfm

Data element attributes

Collection and usage attributes

Guide for use: This coding is to be used in conjunction with specified Body Functions domains. For example, 'a mild impairment of functions related to the brain' to indicate the area of impairment and, potentially, the sorts of interventions that may result in improved functioning. The body function in which an individual experiences an impairment is indicated using the metadata item Person—body function, code (ICF 2001) AN[NNNN].

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references: See also Person—body function, code (ICF 2001) AN[NNNN] Health, Standard 29/11/2006, Community services, Standard 16/10/2006

Implementation in Data Set Specifications: Body functions cluster Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Impairment of body structure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—extent of impairment of body structure, code (ICF 2001) N
METeOR identifier:	320165
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	A person's degree of impairment in a specified body structure, as represented by a code.
Data Element Concept:	Person—extent of impairment of body structure

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Functioning, Disability and Health 2001
Representation class:	Code
Data type:	String
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
0	No impairment
1	Mild impairment
2	Moderate impairment
3	Severe impairment
4	Complete impairment

Supplementary values:

Value	Meaning
8	Not specified
9	Not applicable

Collection and usage attributes

Guide for use:

This metadata item contributes to the definition of the concept '**Disability**' and gives an indication of the experience of disability for a person.

Impairments of body structure or body function are problems in body structure or function such as a loss or significant departure from population standards or averages.

CODE 0 No impairment

Used when there is no significant variation from accepted population standards in the biomedical status of the body structure or its functions [0-4%].

CODE 1 Mild impairment

Used when there is a slight or low variation from accepted

population standards in the biomedical status of the body structure or its functions [5-24%].

CODE 2 Moderate impairment

Used when there is a medium (significant but not severe) variation from accepted population standards in the biomedical status of the body structure or its functions [25-49%].

CODE 3 Severe impairment

Used when there is an extreme variation from accepted population standards in the biomedical status of the body structure or its functions [50-95%].

CODE 4 Complete impairment

Used when there is a total variation from accepted population standards in the biomedical status of the body structure or its functions [96-100%].

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin: World Health Organization (WHO) 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents: Further information on the ICF including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website http://www.who.int/classifications/icf/en/
- Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.cfm

Data element attributes

Collection and usage attributes

Guide for use: This data element is used in conjunction with specified body structures, for example 'mild impairment of structures related to movement'. This data element may also be used in conjunction with Person—nature of impairment of body structure, code (ICF 2001) N and Person—location of impairment of body structure, code (ICF 2001) N.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references:	See also Person—location of impairment of body structure, code (ICF 2001) N Health, Standard 29/11/2006, Community services, Standard 16/10/2006 See also Person—nature of impairment of body structure, code (ICF 2001) N Health, Standard 29/11/2006, Community services, Standard 16/10/2006
Implementation in Data Set Specifications:	Body structures cluster Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Indicator procedure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—indicator procedure, code NN
METeOR identifier:	334976
Registration status:	Health, Standard 07/12/2005
Definition:	Indicator procedure for which an elective surgery patient is waiting, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode—indicator procedure

Value domain attributes

Representational attributes

Classification scheme:	Australian Classification of Health Interventions (ACHI) 5th edition
Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Cataract extraction
02	Cholecystectomy
03	Coronary artery bypass graft
04	Cystoscopy
05	Haemorrhoidectomy
06	Hysterectomy
07	Inguinal herniorrhaphy
08	Myringoplasty
09	Myringotomy
10	Prostatectomy
11	Septoplasty
12	Tonsillectomy
13	Total hip replacement
14	Total knee replacement
15	Varicose veins stripping and ligation

Supplementary values:

16	Not applicable

Data element attributes

Collection and usage attributes

Guide for use:

The procedure terms are defined by the Australian Classification of Health Interventions (ACHI) codes which are listed in comments below. 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.

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.

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.

The following is a list of ACHI (5th edition) 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]

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 [1089] 36812-01 [1089] 36836-00 [1098]

Haemorrhoidectomy:

32138-00 [941] 32132-00 [941] 32135-00 [941] 32135-01 [941]

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] 41635-01 [313]

Myringotomy:

41626-00 [309] 41626-01 [309] 41632-00 [309] 41632-01 [309]

Prostatectomy:

37203-00 [1165] 37203-02 [1165] 37207-00 [1166] 37207-01[1166]BR>37203-05 [1166] 37203-06 [1166] 37200-03[1167] 37200-04 [1167] 37209-00[1167] 37200-05 [1167] 90407-00 [1168] 37201-00 [1165] 37203-03 [1166] 37203-04 [1166] 37224-00 [1162] 37224-01 [1162]

Septoplasty:

41671-02 [379] 41671-01 [379] 41671-03 [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]

Source and reference attributes

Origin: National Health Data Committee

Reference documents: National Centre for Classification in Health (NCCH) 2006. The Australian Classification of Health Interventions (ACHI) – Fifth Edition - Tabular list of interventions and Alphabetic index of interventions. Sydney: NCCH, Faculty of Health Sciences, The University of Sydney.

Relational attributes

Related metadata references: Supersedes Elective surgery waiting list episode—indicator procedure, code NN Health, Superseded 07/12/2005

Implementation in Data Set Specifications:

Elective surgery waiting times (census data) NMDS 2006-2009 Health, Superseded 03/12/2008

Implementation start date: 30/09/2006

Implementation end date: 31/03/2009

Elective surgery waiting times (census data) NMDS 2009- Health, Standard 03/12/2008

Implementation start date: 30/06/2009

Elective surgery waiting times (removals data) NMDS 2006-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2006

Implementation end date: 30/06/2009

Elective surgery waiting times (removals data) NMDS 2009- Health, Standard 03/12/2008

Implementation start date: 01/07/2009

Indigenous status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—Indigenous status, code N
METeOR identifier:	291036
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 15/04/2010
Definition:	Whether a person identifies as being of Aboriginal or Torres Strait Islander origin, as represented by a code. This is in accord with the first two of three components of the Commonwealth definition.
Data Element Concept:	Person—Indigenous status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Aboriginal but not Torres Strait Islander origin
2	Torres Strait Islander but not Aboriginal origin
3	Both Aboriginal and Torres Strait Islander origin
4	Neither Aboriginal nor Torres Strait Islander origin

Supplementary values:

Value	Meaning
9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

This metadata item is based on the Australian Bureau of Statistics (ABS) standard for Indigenous status. For detailed advice on its use and application please refer to the ABS Website as indicated in the Reference documents.

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/ inadequately described:

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.
- Where the question was not able to be asked prior to completion of assistance because the client was unable to communicate or a person who knows the client was not available.

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

Data element attributes

Collection and usage attributes

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. It is strongly recommended that this question be asked directly wherever possible.

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

This question must always be asked regardless of data collectors' perceptions based on appearance or other factors.

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).

This approach may be problematical in some data collections, for example when data are collected by interview or using screen based data capture systems. An additional response category

Yes, both Aboriginal and Torres Strait Islander...

may be included if this better suits the data collection practices of the agency or establishment concerned.

Comments:

The following definition, commonly known as 'The Commonwealth Definition', was given in a High Court judgement in the case of Commonwealth v Tasmania (1983) 46 ALR 625.

'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'.

There are three components to the Commonwealth definition:

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

In practice, it is not feasible to collect information on the community acceptance part of this definition in general purpose statistical and administrative collections and therefore standard questions on Indigenous status relate to descent and self-identification only.

Source and reference attributes

Origin:

National Health Data Committee

National Community Services Data Committee

Reference documents:

Australian Bureau of Statistics 1999. Standards for Social, Labour and Demographic Variables. Cultural Diversity Variables, Canberra. Viewed 3 August 2005.

Relational attributes

Related metadata references:

Supersedes Person—Indigenous status, code N Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Admitted patient palliative care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient palliative care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient palliative care NMDS 2007-08 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient palliative care NMDS 2008-09 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient palliative care NMDS 2009-10 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient palliative care NMDS 2010-11 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Alcohol and other drug treatment services NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Community mental health care 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Community mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Community mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Community mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Community mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Computer Assisted Telephone Interview demographic module DSS Health, Superseded 03/12/2008

Computer Assisted Telephone Interview demographic module DSS Health, Standard 03/12/2008

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Elective surgery waiting times (census data) NMDS 2009- Health, Standard 03/12/2008

Implementation start date: 30/06/2009

Elective surgery waiting times (removals data) NMDS 2009- Health, Standard 03/12/2008

Implementation start date: 01/07/2009

Health care client identification DSS Health, Superseded

03/12/2008

Health care client identification DSS Health, Standard 03/12/2008

Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Non-admitted patient emergency department care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Perinatal NMDS Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Perinatal NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Perinatal NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Registered chiropractic labour force DSS Health, Standard 10/12/2009

Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009

Registered medical professional labour force DSS Health, Standard 10/12/2009

Registered midwifery labour force DSS Health, Standard 10/12/2009

Registered nursing professional labour force DSS Health, Standard 10/12/2009

Registered optometry labour force DSS Health, Standard 10/12/2009

Registered osteopathy labour force DSS Health, Standard 10/12/2009

Registered pharmacy labour force DSS Health, Standard 10/12/2009

Registered physiotherapy labour force DSS Health, Standard 10/12/2009

Registered podiatry labour force DSS Health, Standard 10/12/2009

Registered psychology labour force DSS Health, Standard 10/12/2009

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Residential mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Residential mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Individual sessions (public psychiatric, alcohol and drug hospital)—emergency and outpatient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (public psychiatric or alcohol and drug hospital)—number of individual session occasions of service for non-admitted patients (emergency and outpatient), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care (public psychiatric, alcohol & drug) - emergency and outpatient individual sessions
METeOR identifier:	270216
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the emergency and outpatient functional unit of a public psychiatric or alcohol and drug hospital.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:	Emergency patients and outpatients are persons who receive non-admitted care. Individual non-admitted care is care provided to a person 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 person 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.
Comments:	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.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Type of non-admitted patient care (public psychiatric, alcohol & drug), version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.1 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Individual sessions (public psychiatric, alcohol and drug hospital)—outreach and community

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (public psychiatric or alcohol and drug hospital)—number of individual session occasions of service for non-admitted patients (outreach and community), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care (public psychiatric, alcohol & drug) - outreach and community individual sessions
METeOR identifier:	270218
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients by outreach and community services units of a public psychiatric or alcohol and drug hospital.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:	For outreach/community patients, care is delivered by hospital employees to the patient in the home, place of work or other non-hospital site.
Comments:	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.

Source and reference attributes

Submitting organisation:	National minimum data set working parities

Relational attributes

Related metadata references:

Supersedes Type of non-admitted patient care (public psychiatric, alcohol & drug), version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.1 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Individual sessions—alcohol and drug

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (alcohol and drug), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care - alcohol and drug individual sessions
METeOR identifier:	270508
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the alcohol and drug functional unit of an establishment.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:	For occasions of service as individual sessions to non-admitted patients attending designated drug and alcohol units within hospitals. This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification. 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. The list of Type of non-admitted patient care 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.

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.

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.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Individual sessions—allied health services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (allied health services), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care - allied health services individual sessions
METeOR identifier:	270502
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients by allied health services units or clinics of an establishment.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:	Allied health service units include those units primarily concerned with physiotherapy, speech therapy, family planning, dietary advice, optometry, occupational therapy, and so on. This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification. 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. The list of Type of non-admitted patient care 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.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Individual sessions—community health services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (community health services), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care - community health services individual sessions
METeOR identifier:	270395
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in designated community health services units of an establishment.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:

For 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

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

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.

The list of Type of non-admitted patient care 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.

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.

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.

Source and reference attributes

Submitting organisation:

National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Individual sessions—dental

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (dental), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care - dental individual sessions
METeOR identifier:	270513
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in designated dental units of an establishment.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:

For all occasions of service as individual sessions to non-admitted patients attending designated dental units within hospitals.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

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.

The list of Type of non-admitted patient care 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.

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.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health,

Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Individual sessions—dialysis

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (dialysis), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care - dialysis individual sessions
METeOR identifier:	270503
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the dialysis functional unit of an establishment.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:

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.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

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.

The list of Type of non-admitted patient care 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.

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.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Individual sessions—district nursing services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (district nursing services), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care - district nursing services individual sessions
METeOR identifier:	270512
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients by the district nursing services functional unit of an establishment.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:

For occasions of service as individual sessions by district nursing services to non-admitted patients.

District nursing services:

- 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.

*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.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

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.

The list of Type of non-admitted patient care 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.

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.

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.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Individual sessions—emergency services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (emergency services), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care
METeOR identifier:	270506
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the emergency services functional unit of an establishment.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:

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.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

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. The list of Type of non-admitted patient care 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.

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.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Individual sessions—endoscopy and related procedures

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (endoscopy and related procedures), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care - endoscopy and related procedures individual sessions
METeOR identifier:	270507
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the endoscopy and related procedures functional unit of an establishment.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:

For all occasions of endoscopy and related procedures provided as individual sessions to non-admitted patients.

Endoscopy and related procedures include:

- 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 for admitted patients are excluded from this category.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

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.

The list of Type of non-admitted patient care 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.

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.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Individual sessions—mental health

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (mental health), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care - mental health individual sessions
METeOR identifier:	270504
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the mental health functional unit of an establishment.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:	For all occasions of service as individual sessions to non-admitted patients attending designated psychiatric or mental health units within hospitals. This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification. 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. The list of Type of non-admitted patient care 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.

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.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Individual sessions—other medical/surgical/diagnostic

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (other medical/surgical/diagnostic), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care - other medical/surgical/diagnostic individual sessions
METeOR identifier:	270511
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other service provided to a patient in a medical/surgical/diagnostic unit of a health service establishment not defined elsewhere. 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.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:

For 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 have not already been covered in other data elements.

Other medical/surgical/diagnostic services include:

- electrocardiogram (ECG)
- obstetrics
- nuclear medicine
- general medicine
- general surgery
- fertility etc.

This metadata item identifies types of services provided to

non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

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.

The list of Type of non-admitted patient care 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.

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 from 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.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Individual sessions—other outreach services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (other outreach services), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care
METeOR identifier:	270514
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients through the outreach services of an establishment not defined elsewhere.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:

For occasions of outreach services as individual sessions to non-admitted patients.

Other outreach services:

- 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.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

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.

The list of Type of non-admitted patient care 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.

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.

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.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Individual sessions—pathology

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (pathology), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care
METeOR identifier:	270505
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the pathology functional unit of an 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.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:	For all occasions of service as individual sessions to non-admitted patients from designated pathology laboratories. Occasions of service to all patients from other establishments should be counted separately. This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification. 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. The list of Type of non-admitted patient care 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.

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.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health,

Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Individual sessions—pharmacy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (pharmacy), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care
METeOR identifier:	270509
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the pharmacy functional unit of an establishment.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:	For all occasions of service as individual sessions 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. This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification. 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. The list of Type of non-admitted patient care 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.

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.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Individual sessions—radiology and organ imaging

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session occasions of service for non-admitted patients (radiology and organ imaging), total N[NNNNNN]
Synonymous names:	Type of non-admitted patient care
METeOR identifier:	270510
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the radiology and organ imaging functional unit of an establishment.
Data Element Concept:	Establishment—number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:	For all occasions of radiology and organ imaging services as individual sessions to non-admitted patients. Radiology and organ imaging includes services undertaken in radiology (X-ray) departments as well as in specialised organ imaging clinics carrying out ultrasound, computerised tomography (CT) and magnetic resonance imaging (MRI). This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification. 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.

The list of Type of non-admitted patient care 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.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Supersedes Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Individual/group session indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service contact—group session status, individual/group session indicator code ANN.N
METeOR identifier:	291057
Registration status:	Health, Standard 04/05/2005
Definition:	Whether two or more patients received services at the same time from the same hospital staff, as represented by a code.
Data Element Concept:	Service contact—group session status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	ANN.N
Maximum character length:	5

Permissible values:

Value	Meaning
A12.1	Individual sessions
A12.2	Group sessions

Data element attributes

Collection and usage attributes

Guide for use: 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.

Relational attributes

Related metadata references: Supersedes Individual/group session, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.5 KB)

Infant weight, neonate, stillborn

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth—birth weight, total grams NNNN
METeOR identifier:	269938
Registration status:	Health, Standard 01/03/2005
Definition:	The first weight, in grams, 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.
Data Element Concept:	Birth—birth weight

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NNNN
Maximum character length:	4
Unit of measure:	Gram (g)

Data element attributes

Collection and usage attributes

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.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Infant weight, neonate, stillborn, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.2 KB)
Implementation in Data Set Specifications:	Perinatal NMDS Health, Superseded 06/09/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007

Perinatal NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Perinatal NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Influence of environmental factor

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—extent of environmental factor influence, code (ICF 2001) [X]N
METeOR identifier:	320198
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The degree to which a specified environmental factor influences the body function or structure, the activity or participation of a person, as represented by a code.
Context:	The environment in which a person functions or experiences disability.
Data Element Concept:	Person—extent of environmental factor influence

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Functioning, Disability and Health 2001
Representation class:	Code
Data type:	String
Format:	[X]N
Maximum character length:	2

Permissible values:

Value	Meaning
0	No barrier
1	Mild barrier
2	Moderate barrier
3	Severe barrier
4	Complete barrier
+0	No facilitator
+1	Mild facilitator
+2	Moderate facilitator
+3	Substantial facilitator
+4	Complete facilitator

Supplementary values:

8	Barrier not specified
+8	Facilitator not specified
9	Not applicable

Collection and usage attributes

Guide for use:	This metadata item contributes to the definition of the concept '**Disability**' and gives an indication of the experience of disability for a person.

Extent of influence of environmental factors corresponds to the degree, strength or magnitude of the influence and the amount of time the influence is experienced by the person. It is essentially a summary measure, in which are embedded the concepts of availability, quality and importance, that indicates the effect the specified environmental factor has on the person.

Whether, and by how much, environmental factors are influencing an individual's level of functioning, and whether the influence is a facilitator or barrier, may indicate the sorts of interventions that will optimise the individual's functioning. This information may be for policy development, service provision, or advocacy purposes. Preventative strategies could be indicated by this information.

This value domain can be used to collect information across the whole spectrum of influence, for example, tactile flooring may be a facilitator to a person with visual impairment and a barrier to a person with mobility impairments. In line with the ICF approach to functioning and disability, this value domain recognises, and gives the means to record, the positive influence of environmental factors as well as those factors that limit the level of functioning of a person.

The codes are mutually exclusive. The choice of codes depends on the context of the data collection. For example; if collecting information about the positive influence of an environmental factor such as a community service it would be appropriate to use Code 0 No facilitator if the service was not influencing the person's level of functioning (even if the service were not a barrier to the person's functioning).

Code +0 No facilitator:

Used when the environment factor does not impact in a positive way on the body structure or function, activity or participation of a person.

Code +1 Mild facilitator:

Used when the environmental factor impacts in a positive way on the body structure or function, activity or participation of a person between 5-24% of the time the person participates in the specified domain of functioning or has a low level of impact on the person's functioning.

Code +2 Moderate facilitators:

Used when the environmental factor impacts in a positive way on the body structure or function, activity or participation of a person between 25-49% of the time the person participates in the specified domain of functioning or has a significant, but moderate impact on the person's functioning.

Code +3 Substantial facilitators:

Used when the environmental factor impacts in a positive way on the body structure or function, activity or participation of a person between 50-95% of the time the person participates in the specified domain of functioning or has an extreme effect on the person's functioning.

Code +4 Complete facilitators:

Used when the environmental factor impacts in a positive way on the body structure or function, activity or participation of a person between 96-100% of the time the person participates in the specified domain of functioning or the person functions optimally with this environmental factor.

Code +8 Facilitator not specified:

Used when there is insufficient information to record the Extent of environmental influence code (ICF 2001) N in classes +1 to +4.

Code 0 No barrier:

Used when the environment factor does not impact in a negative way on the body structure or function, activity or participation of a person.

Code 1 Mild barriers:

Used when the environmental factor impacts in a negative way on the body structure or function, activity or participation of a person between 5-24% of the time the person participates in the specified domain of functioning or has a low level of impact on the person's functioning.

Code 2 Moderate barriers:

Used when the environmental factor impacts in a negative way on the body structure or function, activity or participation of a person between 25-49% of the time the person participates in that specified domain of functioning or has a significant, but moderate impact on the person's functioning.

Code 3 Severe barriers:

Used when the environmental factor impacts in a negative way on the body structure or function, activity or participation of a person between 50-95% of the time the person participates in that specified domain of functioning or has an extreme effect on the person's functioning.

Code 4 Complete barriers:

Used when the environmental factor impacts in a negative way on the body structure or function, activity or participation of a person between 96-100% of the time the person participates in the specified domain of functioning or is of such magnitude that the person is unable to function.

Code 8 Barrier not specified:

Used when there is insufficient information to record the Extent of environmental influence code (ICF 2001) N in classes 1 to 4.

Code 9 Not applicable:

Used when environmental factors impacts in neither a positive or negative way on the body structure or function, activity or participation of a person or for between 0-4% of the time the person participates in that specified area and has minimal impact on the person's level of functioning in the specified domain.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin: WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents: Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website http://www.who.int/classifications/icf/en/
- Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.cfm

Data element attributes

Collection and usage attributes

Guide for use: Environmental factors represent the circumstances in which the individual lives. These factors are conceived as immediate (e.g. physical features of the environment, social environment) and societal (formal and informal social structures, services and systems). Different environments may have a very different impact on the same individual with a given health condition.

The influence of environmental factors may be positive, increasing the level of functioning (a facilitator), or negative, decreasing the level of functioning (a barrier).

The extent of influence of the **Environmental factors** is affected both by the degree, strength of influence, and the amount of time the influence is experienced by the person.

This metadata item is recorded in conjunction with *Environmental factor code N* to indicate the extent to which specified environmental factors influence the body function or structure, the activity or participation of a person.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references: See also Person—environmental factor, code (ICF 2001) AN[NNN] Health, Standard 29/11/2006, Community services, Standard 16/10/2006

Implementation in Data Set Specifications: Environmental factors cluster Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Informal carer existence indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—informal carer existence indicator, code N
Synonymous names:	Informal carer availability, Informal carer existence flag, Carer arrangements (informal)
METeOR identifier:	320939
Registration status:	Health, Standard 04/07/2007 Community services, Standard 29/04/2006
Definition:	Whether a person has an **informal carer**, as represented by a code.
Data Element Concept:	Person—informal carer existence indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	Informal carers may include those people who receive a pension or benefit for their caring role and people providing care under family care agreements. Excluded from the definition of informal carers are volunteers organised by formal services and paid workers. This metadata item is purely descriptive of a client's circumstances. It is not intended to reflect whether the informal carer is considered by the service provider to be capable of undertaking the caring role. The expressed views of the client and/or their carer should be used as the basis for determining whether the client is recorded as having an informal carer or not. When asking a client whether they have an informal carer, it is

important for agencies or establishments to recognise that a carer does not always live with the person for whom they care. That is, a person providing significant care and assistance to the client does not have to live with the client in order to be called an informal carer.

Collection methods:

Agencies or establishments and service providers may collect this item at the beginning of each service episode and /or assess this information at subsequent assessments.

Some agencies, establishments/providers may record this information historically so that they can track changes over time. Historical recording refers to the practice of maintaining a record of changes over time where each change is accompanied by the appropriate date.

Examples of questions that have been used for data collection include:

Home and Community Care NMDS

'Do you have someone who helps look after you?'

Commonwealth State/Territory Disability Agreement NMDS

*'Does the service user have an informal carer, such as **family** member, friend or neighbour, who provides care and assistance on a regular and sustained basis?*

Comments:

Recent years have witnessed a growing recognition of the critical role that informal support networks play in caring for frail older people and people with disabilities within the community. Not only are informal carers responsible for maintaining people with often high levels of functional dependence within the community, but the absence of an informal carer is a significant risk factor contributing to institutionalisation. Increasing interest in the needs of carers and the role they play has prompted greater interest in collecting more reliable and detailed information about carers and the relationship between informal care and the provision of and need for formal services.

This definition of informal carer is not the same as the Australian Bureau of Statistics (ABS) definition of principal carer, 2003 Survey of Disability, Ageing and Carers and primary carer used in the 1998 survey. The ABS definitions require that the carer has or will provide care for a certain amount of time and that they provide certain types of care.

The ABS defines a primary carer as a person of any age who provides the most informal assistance, in terms of help or supervision, to a person with one or more disabilities. The assistance has to be ongoing, or likely to be ongoing, for at least six months and be provided for one or more of the core activities (communication, mobility and self care). This may not be appropriate for community services agencies wishing to obtain information about a person's carer regardless of the amount of time that care is for, or the types of care provided.

Information such as the amount of time for which care is provided can of course be collected separately but, if it were not needed, it would place a burden on service providers.

Source and reference attributes

Origin:	Australian Institute of Health and Welfare
	National Health Data Committee
	National Community Services Data Committee
Reference documents:	Australian Bureau of Statistics (ABS) 1993 Disability, Ageing and Carers Survey and 2003 Survey of Disability, Ageing and Carers.
	Australian Institute of Health and Welfare (2005) Commonwealth State/Territory Disability Agreement National Minimum Data Set collection (CSTDA NMDS) Data Guide: 2005-06.
	National HACC Minimum Data Set User Guide Version 2 July 2005. Home and Community Care (HACC) Program.

Relational attributes

Related metadata references:	Supersedes Person (requiring care)—carer availability status, code N Health, Superseded 04/07/2007, Community services, Superseded 29/04/2006
Implementation in Data Set Specifications:	Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009
	Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Initial visit indicator—diabetes mellitus

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—initial visit since diagnosis indicator (diabetes mellitus), code N
METeOR identifier:	302470
Registration status:	Health, Standard 21/09/2005
Definition:	Whether the visit to a health professional is an initial visit for diabetes, or other related condition, after a diagnosis of diabetes, as represented by a code.
Data Element Concept:	Patient—initial visit since diagnosis indicator (diabetes mellitus)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 9 Not stated/inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use: CODE 1 Yes: Record if this is the initial visit of the patient for diabetes, or a related condition, after diagnosis.

CODE 2 No: Record if this is not the initial visit of the patient for diabetes, or a related condition, after diagnosis.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references: Supersedes Patient—initial visit since diagnosis status (diabetes

	mellitus), code N Health, Superseded 21/09/2005
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Standard 21/09/2005

Injecting drug use status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Client—injecting drug use status, code N
METeOR identifier:	270113
Registration status:	Health, Standard 01/03/2005
Definition:	The client's use of injection as a method of administering drugs, as represented by a code.
Data Element Concept:	Client—injecting drug use status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Last injected three months ago or less
2	Last injected more than three months ago but less than or equal to twelve months ago
3	Last injected more than twelve months ago
4	Never injected

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Collection methods:

To be collected on commencement of treatment with a service.

For clients whose treatment episode is related to the alcohol and other drug use of another person, this metadata item should not be collected.

Comments:

This metadata item 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 metadata item 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.

This metadata item is important for identifying patterns of drug use and harms associated with injecting drug use.

Source and reference attributes

Submitting organisation: Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references: Supersedes Injecting drug use status, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.8 KB)

Implementation in Data Set Specifications: Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Alcohol and other drug treatment services NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Instrumented bleeding location

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with acute coronary syndrome—bleeding location, instrumented code N(N)
Synonymous names:	Instrumented bleeding site
METeOR identifier:	344787
Registration status:	Health, Standard 01/10/2008
Definition:	The location of the person's bleeding episode, arising from an instrumented site, as represented by a code.
Data Element Concept:	Person with acute coronary syndrome—bleeding location

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	Percutaneous coronary procedure arterial access site
2	Coronary artery bypass graft site
3	Gastrointestinal site
4	Genitourinary site
5	Intracranial site
6	Pulmonary site
7	Pericardial site
8	Other site(s)
9	Unidentified site

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Percutaneous coronary procedure arterial access site

Use this code when the person's bleeding is originating from the site of arterial access for a percutaneous coronary procedure. Procedures may include cardiac catheterisation, percutaneous coronary intervention, angiogram, intra-aortic balloon pump and/or arterial pressure monitoring sheaths.

CODE 2 Coronary artery bypass graft site

Use this code when the person's bleeding is originating from the site of a coronary artery bypass graft.

CODE 3 Gastrointestinal site

Use this code when the person's bleeding is originating from the gastrointestinal area with mechanical instrumentation.

CODE 4 Genitourinary site

Use this code when the person's bleeding is originating from the genitourinary area with mechanical instrumentation.

CODE 5 Intracranial site

Use this code when the person's bleeding is originating from an intracranial site with mechanical instrumentation.

CODE 6 Pulmonary site

Use this code when the person's bleeding is originating from a pulmonary site with mechanical instrumentation.

CODE 7 Pericardial site

Use this code when the person's bleeding is originating from the pericardium, following percutaneous coronary intervention. This code does not include bleeding that is secondary to a coronary artery bypass graft.

CODE 8 Other site(s)

Use this code when the person's bleeding is originating from a site with mechanical instrumentation that is not listed in codes 1-7, such as central line access.

CODE 9 Unidentified site

Use this code when the person has a fall in haemoglobin without an identifiable instrumented site of bleeding.

CODE 99 Not stated/inadequately described

Not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use: Record the location of all bleeding events that occur. More than one code can be applied.

Relational attributes

Related metadata references: See also Person—bleeding episode status, Thrombolysis in Myocardial Infarction (TIMI) code N Health, Standard 01/10/2008

See also Person with acute coronary syndrome—bleeding location, non-instrumented code N(N) Health, Standard 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Intended length of hospital stay

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—intended length of hospital stay, code N
METeOR identifier:	270399
Registration status:	Health, Standard 01/03/2005
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, as represented by a code.
Data Element Concept:	Episode of admitted patient care—intended length of hospital stay

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Intended same-day
2	Intended overnight

Data element attributes

Collection and usage attributes

Collection methods: The intended length of stay should be ascertained for all admitted patients at the time the patient is admitted to hospital.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Intended length of hospital stay, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB)

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v 6) NN Health, Standard 22/12/2009

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v 6) ANNA Health, Standard 22/12/2009

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA Health, Superseded 22/12/2009

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN Health, Superseded 22/12/2009

Implementation in Data Set Specifications:

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Intended place of birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—setting of birth (intended), code N
METeOR identifier:	269980
Registration status:	Health, Standard 01/03/2005
Definition:	The intended place of birth at the onset of labour, as represented by a code.
Context:	Perinatal care
Data Element Concept:	Birth event—setting of birth

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Hospital, excluding birth centre
2	Birth centre, attached to hospital
3	Birth centre, free standing
4	Home
8	Other

Supplementary values:

Value	Meaning
9	Not stated

Collection and usage attributes

Comments: The development of a definition of a birth centre is currently under consideration by the Commonwealth in conjunction with the states and territories.

Data element attributes

Collection and usage attributes

Guide for use:

Code 1 Hospital, excluding birth centre

Hospital, excluding birth centre, includes for women who have elective caesarean sections

Code 4 Home

Home, should be restricted to the home of the woman or a relative or friend.

Code 8 Other

Other, includes community (health) centres.

Comments: 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.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Intended place of birth, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.9 KB)

Intended years in health profession

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—intended years in profession, total years NN
METeOR identifier:	375487
Registration status:	Health, Standard 10/12/2009
Definition:	The total number of years a health professional expects to remain practising in the registered profession.
Context:	Registered health labour force
Data Element Concept:	Registered health professional—intended years in profession

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	String	
Format:	NN	
Maximum character length:	2	
Supplementary values:	Value	Meaning
	99	Not stated/inadequately described
Unit of measure:	Year	

Data element attributes

Collection and usage attributes

Guide for use:	Total years expressed as 00, 01 etc.
Comments:	The data element is an estimate of the future plans of the health professional, providing an indication of the future losses from the health labour force. It should be noted that the health professional's intentions may change therefore these data should be used with care.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:	Registered chiropractic labour force DSS Health, Standard 10/12/2009
	Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009
	Registered medical professional labour force DSS Health, Standard 10/12/2009
	Registered midwifery labour force DSS Health, Standard 10/12/2009

Registered nursing professional labour force DSS Health, Standard 10/12/2009

Registered optometry labour force DSS Health, Standard 10/12/2009

Registered osteopathy labour force DSS Health, Standard 10/12/2009

Registered pharmacy labour force DSS Health, Standard 10/12/2009

Registered physiotherapy labour force DSS Health, Standard 10/12/2009

Registered podiatry labour force DSS Health, Standard 10/12/2009

Registered psychology labour force DSS Health, Standard 10/12/2009

Intention of treatment for cancer

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—intention of treatment, code N
METeOR identifier:	288690
Registration status:	Health, Standard 04/06/2004
Definition:	The intention of the initial treatment for cancer for the particular patient, as represented by a code.
Data Element Concept:	Cancer treatment—intention of treatment

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Prophylactic
2	Curative
3	Non-curative or palliative

Supplementary values:

Value	Meaning
0	Did not have treatment
9	Not stated

Collection and usage attributes

Guide for use:

CODE 0 Did not have treatment

This code is used when the patient did not have treatment as part of the initial management plan

CODE 1 Prophylactic

This code is used when the cancer has not developed

CODE 2 Curative

This code is used when treatment is given for control of the disease

CODE 3 Non-curative or Palliative

This code is used when the cure is unlikely to be achieved and treatment is given primarily for the purpose of pain control. Other benefits of the treatment are considered secondary contributions to the patient's quality of life

CODE 9 Intention was not stated

Patient had treatment for cancer but the intention was not stated.

Data element attributes

Collection and usage attributes

Guide for use: This item is collected for surgical treatment, radiation therapy and systemic therapy agent treatment.

Source and reference attributes

Submitting organisation: National Cancer Control Initiative

Origin: Commission on Cancer, American College of Surgeons

New South Wales Health Department

Reference documents: Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Public Health Division NSW Clinical Cancer Data Collection for Outcomes and Quality. Data Dictionary Version 1 Sydney NSW Health Dept (2001)

Relational attributes

Related metadata references: Supersedes Intention of treatment for cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.9 KB)

Implementation in Data Set Specifications: Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Superseded 06/03/2009

Cancer (clinical) DSS Health, Superseded 22/12/2009

Cancer (clinical) DSS Health, Standard 22/12/2009

Inter-hospital contracted patient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—inter-hospital contracted patient status, code N
METeOR identifier:	270409
Registration status:	Health, Standard 01/03/2005
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, as represented by a code.
Data Element Concept:	Episode of admitted patient care—inter-hospital contracted patient status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Inter-hospital contracted patient from public sector hospital
2	Inter-hospital contracted patient from private sector hospital
3	Not contracted

Supplementary values:

9	Not reported

Data element attributes

Collection and usage attributes

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.

This data element item 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.

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.

Source and reference attributes

Origin:

National Health Data Committee

Relational attributes

Related metadata references:

Is formed using Hospital—contract type, code N Health, Standard 01/03/2005

Is formed using Hospital—contract role, code A Health, Standard 01/03/2005

Supersedes Inter-hospital contracted patient, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.3 KB)

Implementation in Data Set Specifications:

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Interpreter services required

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—interpreter service required, yes/no code N
Synonymous names:	Need for interpreter service
METeOR identifier:	304294
Registration status:	Health, Standard 08/02/2006 Community services, Standard 10/04/2006
Definition:	Whether an interpreter service is required by or for the person, as represented by a code.
Data Element Concept:	Person—interpreter service required

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

Includes verbal language, non verbal language and languages other than English.

CODE 1 Yes

Use this code where interpreter services are required.

CODE 2 No

Use this code where interpreter services are not required.

Persons requiring interpreter services for any form of sign language should be coded as Interpreter required.

Collection methods:

Recommended question:

Do you [does the person] require an interpreter?

Yes

No

Relational attributes

Related metadata references:

Supersedes Person—interpreter service required status (health), code N Health, Superseded 08/02/2006

Jobseeker status in registered profession

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—jobseeker status in registered profession, code N
METeOR identifier:	383449
Registration status:	Health, Standard 10/12/2009
Definition:	Whether a registered health professional is looking for work in their registered profession, as represented by a code.
Data Element Concept:	Registered health professional—jobseeker status in registered profession

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Looking for work in Australia
2	Not looking for work in Australia

Supplementary values:

Value	Meaning
9	Unknown/inadequately described

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:

This data element is applicable to all health professionals who are not employed in Australia in the registered profession. It includes health professionals who are:

- employed in the registered profession overseas
- employed outside of the registered profession, and
- not employed at all.

Data are self-reported based on the jobseeker status in the registered profession in the week before registration.

CODE 1 LOOKING FOR WORK IN AUSTRALIA

This category includes persons who are not currently employed in the registered profession in Australia and who are actively looking for work in the registered profession in Australia.

'Actively looking for work' includes writing, telephoning or

applying in person to an employer for work. It also includes answering a newspaper advertisement for a job, checking factory or job placement agency notice boards, being registered with a job placement agency, checking or registering with any other employment agency, advertising or tendering for work or contacting friends or relatives.

CODE 2 NOT LOOKING FOR WORK IN AUSTRALIA

All persons who are not 'looking for work in Australia' as defined above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Labour force status cluster Health, Standard 10/12/2009

Killip classification code

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—Killip classification, code N
METeOR identifier:	285151
Registration status:	Health, Standard 04/06/2004
Definition:	The Killip class, as a measure of haemodynamic compromise, of the person at the time of presentation, as represented by a code.
Data Element Concept:	Person—Killip classification

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Class 1
2	Class 2
3	Class 3
4	Class 4

Supplementary values:

Value	Meaning
8	Other
9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Rales or crepitations represent evidence of pulmonary interstitial oedema on lung auscultation and an S_3 is an audible extra heart sound by cardiac auscultation.

CODE 1 Class 1

Absence of crepitations/rales over the lung fields and absence of S_3.

CODE 2 Class 2

Crepitations/rales over 50% or less of the lung fields or the presence of an S_3.

CODE 3 Class 3

Crepitations/rales over more than 50% of the lung fields.

CODE 4 Class 4

Cardiogenic Shock. Clinical criteria for cardiogenic shock are hypotension (a systolic blood pressure of less than 90 mmHg for at least 30 minutes or the need for supportive measures to maintain a systolic blood pressure of greater than or equal to 90 mmHg), end-organ hypoperfusion (cool extremities or a urine

output of less than 30 ml/h, and a heart rate of greater than or equal to 60 beats per minute). The haemodynamic criteria are a cardiac index of no more than 2.2 l/min per square meter of body-surface area and a pulmonary-capillary wedge pressure of at least 15 mmHg.

Data element attributes

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Steward: The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references: Supersedes Killip classification code, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.7 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Labour force status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—labour force status, code N
METeOR identifier:	270112
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 01/03/2005
Definition:	The self reported status the person currently has in being either in the labour force (employed/unemployed) or not in the labour force, as represented by a code.
Data Element Concept:	Person—labour force status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Employed
2	Unemployed
3	Not in the labour force

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Employed:

Persons aged 15 years and over who, during the reference week:

(a) worked for one hour or more for pay, profit, commission or payment in kind in a job or business, or on a farm (comprising 'Employees', 'Employers' and 'Own Account Workers'); or

(b) worked for one hour or more without pay in a family business or on a farm (i.e. 'Contributing Family Worker'); or

(c) were 'Employees' who had a job but were not at work and were:

- on paid leave
- on leave without pay, for less than four weeks, up to the end of the reference week
- stood down without pay because of bad weather or plant breakdown at their place of employment, for less than four weeks up to the end of the reference week
- on strike or locked out

- on workers' compensation and expected to be returning to their job, or
- receiving wages or salary while undertaking full-time study; or

(d) were 'Employers', 'Own Account Workers' or 'Contributing Family Workers' who had a job, business or farm, but were not at work.

CODE 2 Unemployed:

Unemployed persons are those aged 15 years and over who were not employed during the reference week, and:

(a) had actively looked for full-time or part-time work at any time in the four weeks up to the end of the reference week. Were available for work in the reference week, or would have been available except for temporary illness (i.e. lasting for less than four weeks to the end of the reference week). Or were waiting to start a new job within four weeks from the end of the reference week and would have started in the reference week if the job had been available then; or

(b) were waiting to be called back to a full-time or part-time job from which they had been stood down without pay for less than four weeks up to the end of the reference week (including the whole of the reference week) for reasons other than bad weather or plant breakdown. Note: Actively looking for work includes writing, telephoning or applying in person to an employer for work. It also includes answering a newspaper advertisement for a job, checking factory or job placement agency notice boards, being registered with a job placement agency, checking or registering with any other employment agency, advertising or tendering for work or contacting friends or relatives.

CODE 3 Not in the Labour Force:

Persons not in the labour force are those persons aged 15 years and over who, during the reference week, were not in the categories employed or unemployed, as defined. They include persons who were keeping house (unpaid), retired, voluntarily inactive, permanently unable to work, persons in institutions (hospitals, gaols, sanatoriums, etc.), trainee teachers, members of contemplative religious orders, and persons whose only activity during the reference week was jury service or unpaid voluntary work for a charitable organisation.

Collection methods:

For information about collection, refer to the ABS website:

http://www.abs.gov.au/Ausstats/abs@.nsf/0/AEB5AA310D68DF8FCA25697E0018FED8?Open

Source and reference attributes

Origin:

Australian Bureau of Statistics 1995. Directory of Concepts and Standards for Social, Labour and Demographic Variables. Australia 1995. Cat. no. 1361.0.30.001. Canberra: AGPS.

http://www.abs.gov.au/Ausstats/abs@.nsf/0/AEB5AA310D68DF8FCA25697E0018FED8?Open (last viewed 21 December 2005)

Data element attributes

Collection and usage attributes

Comments: Labour force status is one indicator of the socio-economic status of a person and is a key element in assessing the circumstances and needs of individuals and families.

Source and reference attributes

Origin: Health Data Standards Committee

Relational attributes

Related metadata references: Supersedes Labour force status, version 3, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005.pdf (19.5 KB)

Implementation in Data Set Specifications:

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Laterality of primary cancer

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—laterality of primary cancer, code [N]
METeOR identifier:	270177
Registration status:	Health, Standard 01/03/2005
Definition:	The side of a paired organ that is the origin of the primary cancer, as represented by a code.
Data Element Concept:	Person with cancer—laterality of primary cancer

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A
Maximum character length:	1

Permissible values:

Value	Meaning
R	Right
L	Left
B	Bilateral

Supplementary values:

N	Not applicable
U	Unknown

Data element attributes

Collection and usage attributes

Guide for use:

The valid International Classification of Diseases for Oncology values for the variable are provided in the list below:

Right

Origin of primary site is on the right side of a paired organ.

Left

Origin of primary site is on the left side of a paired organ.

Paired organs are: Breast (C50), Lung (C34), Kidney (C64), Ovary (C56), Eyes (C69), Arms (C76.4, C44.6, C49.1, C47.1, C40.0, C77.3,), Legs (C76.5, C44.7, C49.2, C47.2, C40.2, C77.4), Ears (C44.2, C49.0, C30.1), Testicles (C62), Parathyroid glands (C75.0), Adrenal glands (C74.9, C74.0, C74.1), Tonsils (C09.9, C02.4, C11.1, C09.0, C09.1, C03.9), Ureter (C66.9), Carotid body (C75.4), Vas deferens (C63.1), Optic nerve (C72.3)

Bilateral

Includes organs that are bilateral as a single primary (e.g. bilateral retinoblastoma (M9510/3, C69.2), (M9511/3, C69.2),

(M9512/3, C69.2), (C69.6, C48.0), bilateral Wilms tumours (C64.9, M8960/3)) Note: Bilateral cancers are very rare.

Unknown

It is unknown whether, for a paired organ the origin of the cancer was on the left or right side of the body.

Collection methods: This information should be obtained from the patient's pathology report, the patient's medical record, or the patient's medical practitioner/nursing staff.

Source and reference attributes

Origin: World Health Organization

Reference documents: Percy C, Van Holten V, Muir C (eds). International Classification of Diseases for Oncology, 2nd edition. Geneva: WHO, 1990

Relational attributes

Related metadata references: Supersedes Laterality of primary cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.4 KB)

Implementation in Data Set Specifications: Breast cancer (Cancer registries) DSS Health, Standard 06/03/2009

Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Superseded 06/03/2009

Cancer (clinical) DSS Health, Superseded 22/12/2009

Cancer (clinical) DSS Health, Standard 22/12/2009

Leave days from residential care

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of residential care—number of leave days, total N[NN]
METeOR identifier:	270304
Registration status:	Health, Standard 01/03/2005
Definition:	The number of days spent on leave from a residential care service during an episode of residential care.
Data Element Concept:	Episode of residential care—number of leave days

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:

A day is measured from midnight to midnight.

Leave days can occur for a variety of reasons, including:

- treatment by specialised mental health service
- treatment by a non-specialised health service
- time in the community.

The following rules apply in the calculation of leave days:

- the day the **resident** goes on leave is counted as a leave day
- days the resident is on leave is counted as leave days
- the day the resident returns from leave is not counted as a leave day
- if the resident starts a residential stay and goes on leave on the same day, this is not counted as a leave day
- if the resident returns from leave and then goes on leave again on the same day, this is counted as a leave day
- if the resident returns from leave and ends residential care on the same day, the day should not be counted as leave day
- leave days at the end of a residential stay after the commencement of leave are not counted.

If a period of leave is greater than seven days or the resident fails to return from leave, then the residential stay is formally ended.

Relational attributes

Related metadata references:

Supersedes Leave days from residential care, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.6 KB)

Implementation in Data Set Specifications:

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Residential mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Residential mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Length of employment in health profession

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—length of employment in profession in Australia, total years NN
METeOR identifier:	375478
Registration status:	Health, Standard 10/12/2009
Definition:	The total number of years a health professional has been employed in the registered profession in Australia.
Context:	Registered health labour force
Data Element Concept:	Registered health professional—length of employment in profession in Australia

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	String	
Format:	NN	
Maximum character length:	2	
Supplementary values:	Value	Meaning
	99	Not stated/inadequately described
Unit of measure:	Year	

Data element attributes

Collection and usage attributes

Guide for use:	Total years expressed as 00, 01 etc with values rounded up to the next value of years if the remaining time is greater than six full months. The health professional may be employed in more than one profession. This data element applies only to the profession of registration, regardless of length of time spent working in related professions.
Collection methods:	In total, how many years have you worked in the registered profession in Australia? Include full-time and part-time work. Exclude time spent not working and unpaid leave.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

Registered chiropractic labour force DSS Health, Standard 10/12/2009

Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009

Registered medical professional labour force DSS Health, Standard 10/12/2009

Registered midwifery labour force DSS Health, Standard 10/12/2009

Registered nursing professional labour force DSS Health, Standard 10/12/2009

Registered optometry labour force DSS Health, Standard 10/12/2009

Registered osteopathy labour force DSS Health, Standard 10/12/2009

Registered pharmacy labour force DSS Health, Standard 10/12/2009

Registered physiotherapy labour force DSS Health, Standard 10/12/2009

Registered podiatry labour force DSS Health, Standard 10/12/2009

Registered psychology labour force DSS Health, Standard 10/12/2009

Length of non-admitted patient emergency department service episode

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—service episode length, total minutes NNNNN
METeOR identifier:	270404
Registration status:	Health, Standard 01/03/2005
Definition:	The amount of time, measured in minutes, between when a patient presents at an emergency department for an emergency department service episode, and when the non-admitted component of the emergency department service episode has concluded.
Data Element Concept:	Non-admitted patient emergency department service episode—service episode length

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NNNNN
Maximum character length:	5
Unit of measure:	Minute (m)

Data element attributes

Source and reference attributes

Submitting organisation:	National reference group for non-admitted patient data development, 2001-02

Relational attributes

Related metadata references:	Supersedes Length of non-admitted patient emergency department service episode, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.5 KB) Is formed using Health service event—presentation date, DDMMYYYY Health, Standard 01/03/2005 Is formed using Health service event—presentation time, hhmm Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Non-admitted patient emergency department care NMDS

Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Non-admitted patient emergency department care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Length of stay

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—length of stay (excluding leave days), total N[NN]
METeOR identifier:	269982
Registration status:	Health, Standard 01/03/2005
Definition:	The length of stay of a patient, excluding leave days, measured in days.
Data Element Concept:	Episode of admitted patient care—length of stay (excluding leave days)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:	Formula: LOS = Separation date - Admission date - Total leave days The calculation is inclusive of admission and separation dates.
Comments:	Perinatal length of stay metadata items include leave days and so are not included in this metadata item.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Length of stay, version 3, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB) Is formed using Episode of admitted patient care—number of leave days, total N[NN] Health, Standard 01/03/2005 Is formed using Episode of admitted patient care—separation date, DDMMYYYY Health, Standard 01/03/2005 Is formed using Episode of admitted patient care—number of leave periods, total N[N] Health, Standard 01/03/2005 Is formed using Episode of admitted patient care—admission date, DDMMYYYY Health, Standard 01/03/2005

Length of stay (including leave days)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—length of stay (including leave days), total N[NN]
METeOR identifier:	329889
Registration status:	Health, Standard 04/07/2007
Definition:	The total length of stay (LOS) of a patient, including leave days, measured in days.
Data Element Concept:	Episode of admitted patient care—length of stay (including leave days)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:	Formula: LOS (including leave days) = separation date - admission date Total LOS is calculated by subtracting the patient's date of admission from their date of separation. It includes contract days and leave days. For babies born in hospital: 1) only calculate the total LOS of live births and 2) their admission date is the same as their date of birth. A **same-day patient** should be allocated a length of stay of one day. Total LOS relates to the episode of care associated with the birth. Babies born before arrival and still births are not within scope of this data element and should not have a total length of stay reported.
Comments:	All admitted patient episodes of care where it is required to know the total LOS in hospital (including leave days).

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee
Origin:	National Health Data Committee

Relational attributes

Related metadata references:

Is formed using Episode of admitted patient care—separation date, DDMMYYYY Health, Standard 01/03/2005

Is formed using Episode of admitted patient care—admission date, DDMMYYYY Health, Standard 01/03/2005

Supersedes Episode of admitted patient care—length of stay (including leave days), total N[NN] Health, Superseded 04/07/2007

Length of stay (including leave days) (antenatal)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—length of stay (including leave days) (antenatal), total N[NN]
METeOR identifier:	290577
Registration status:	Health, Standard 04/07/2007
Definition:	The length of stay (LOS) of a woman before the birth of her baby, including leave days, measured in days.
Context:	Perinatal
Data Element Concept:	Episode of admitted patient care—length of stay (including leave days)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:

Formula:

LOS (antenatal) = baby's date of birth - mother's admission date

Antenatal LOS is calculated by subtracting the mother's admission date from the baby's date of birth. It includes contract days and leave days.

If the mother's admission date and the baby's date of birth are on the same date, count the LOS as 1 day.

Antenatal length of stay refers only to the admission associated with the birth.

Antenatal LOS relates only to the episode of admitted patient care associated with the birth.

In a multiple pregnancy, the date of birth of the first baby born should be used to calculate the mother's antenatal LOS.

To calculate the total LOS, use the data element - Episode of admitted patient care - length of stay (including leave days) total.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:

Is formed using Person—date of birth, DDMMYYYY Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 20/06/2005

Is formed using Episode of admitted patient care—admission date, DDMMYYYY Health, Standard 01/03/2005

Supersedes Episode of admitted patient care (antenatal)—length of stay (including leave days), total N[NN] Health, Superseded 04/07/2007

Length of stay (including leave days) (postnatal)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—length of stay (including leave days) (postnatal), total N[NN]
METeOR identifier:	300076
Registration status:	Health, Standard 04/07/2007
Definition:	The length of stay (LOS) of a woman following the birth of her baby, including leave days, measured in days.
Context:	Perinatal.
Data Element Concept:	Episode of admitted patient care—length of stay (including leave days)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:

Formula:

LOS (postnatal) = mother's separation date - baby's date of birth

Postnatal LOS is calculated by subtracting the baby's date of birth from the mother's date of separation. It includes contract days and leave days.

If the mother's separation date and the baby's date of birth are on the same date, count the LOS as 1 day.

In a multiple pregnancy, the date of birth of the first baby born should be used to calculate the mother's postnatal LOS.

Postnatal length of stay refers only to the episode of care associated with the birth.

To calculate the total length of stay, use the data element - Episode of admitted patient care - length of stay (including leave days) total.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:

Is formed using Episode of admitted patient care—separation date, DDMMYYYY Health, Standard 01/03/2005

Is formed using Person—date of birth, DDMMYYYY Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 20/06/2005

Supersedes Episode of admitted patient care (postnatal)—length of stay (including leave days), total N[NN] Health, Superseded 04/07/2007

Level of palliative care service

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—level of service delivery, palliative care code N
METeOR identifier:	334508
Registration status:	Health, Standard 05/12/2007
Definition:	The level of specialisation of the palliative care service delivered by a **palliative care agency**, as represented by a code.
Data Element Concept:	Service provider organisation—level of service delivery

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Primary palliative care
2	Specialist palliative care level 1
3	Specialist palliative care level 2
4	Specialist palliative care level 3

Source and reference attributes

Origin:	Palliative Care Australia 2005. A guide to palliative care service development: A population-based approach. Canberra: Palliative Care Australia, p39.

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Primary palliative care

Capability: Clinical management and care coordination including assessment, triage, and referral using a palliative approach for patients with uncomplicated needs associated with a life limiting illness and/or end of life care. Has formal links with a specialist palliative care provider for purposes of referral, consultation and access to specialist care as necessary.

Typical resource profile: General medical practitioner, nurse practitioner, registered nurse, generalist community nurse, aboriginal health worker, allied health staff. Specialist health care providers in other disciplines would be included at this level.

CODE 2 Specialist palliative care level 1

Capability: Provides palliative care for patients, primary carers and families whose needs exceed the capability of primary palliative care providers. Provides assessment and care consistent with needs and provides consultative support, information and advice to primary palliative care providers. Has formal links to primary palliative care providers and level 2 and/or 3 specialist palliative care providers to meet the needs of patients, carers and families with complex problems. Has quality and audit program.

Typical resource profile: Multi–disciplinary team including medical practitioner with skills and experience in palliative care, clinical nurse specialist/consultant, allied health staff, pastoral care and volunteers. A designated staff member if available, coordinates a volunteer service.

CODE 3 Specialist palliative care level 2

Capability: As for level 1, able to support higher resource level due to population base (e.g. regional area). Provides formal education programs to primary palliative care and level 1 providers and the community. Has formal links with primary palliative care providers and level 3 specialist palliative care services for patients, primary carers and families with complex needs.

Typical resource profile: Interdisciplinary team including medical practitioner and clinical nurse specialist/consultant with specialist qualifications. Includes designated allied health and pastoral care staff.

CODE 4 Specialist palliative care level 3

Capability: Provides comprehensive care for the needs of patients, primary carers and families with complex needs. Provides local support to primary palliative care providers, regional level 1 and/or 2 services including education and formation of standards. Has a comprehensive research and teaching role. Has formal links with local primary palliative care providers and with specialist palliative care providers level 1 and 2, and relevant academic units including professorial chairs where available.

Typical resource profile: Interdisciplinary team including a medical director and clinical nurse consultant/nurse practitioner and allied health staff with specialist qualifications in palliative care.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications: Palliative care performance indicators DSS Health, Standard 05/12/2007

Lifestyle counselling type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with acute coronary syndrome—lifestyle counselling type, code N
METeOR identifier:	344710
Registration status:	Health, Standard 01/10/2008
Definition:	The counselling a person has received to modify lifestyle behaviour/s relevant to acute coronary syndromes, as represented by a code.
Data Element Concept:	Person with acute coronary syndrome—lifestyle counselling type

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Diet
	2	Physical activity
	3	Smoking cessation
	4	Weight management
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

Counselling includes any method of individual or group counselling or advice directed towards any of the specific lifestyle behaviours.

This metadata item refers to counselling that was conducted by a healthcare professional during the hospital stay. This may include counselling that was performed in conjunction with referral to a cardiac rehabilitation service.

CODE 1 Diet

Use this code where a person has received counselling on their diet.

CODE 2 Physical activity

Use this code where a person has received counselling encouraging at least 30 to 60 minutes of physical activity in at least five sessions per week.

CODE 3 Smoking cessation

Use this code where a person has received counselling regarding the importance of stopping smoking.

CODE 4 Weight management

Use this code where a person, whose weight is greater than 120% of the ideal weight for height, has received counselling on weight management.

Relational attributes

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Lipid-lowering therapy status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—lipid-lowering therapy status, code NN
METeOR identifier:	285159
Registration status:	Health, Standard 04/06/2004
Definition:	The person's lipid-lowering therapy status, as represented by a code.
Data Element Concept:	Person—lipid-lowering therapy status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
10	Given
21	Not given - patient refusal
22	Not given - true allergy to lipid lowering therapy
23	Not given - previous myopathy
24	Not given - hepatic dysfunction
25	Not given - other

Supplementary values:

Value	Meaning
90	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODES 21 - 25 Not given

If recording 'Not given', record the principal reason if more than one code applies.

Data element attributes

Source and reference attributes

Submitting organisation:	Acute coronary syndrome working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Lipid-lowering therapy status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Listing date for care

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective care waiting list episode—listing date for care, DDMMYYYY
METeOR identifier:	269957
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a hospital or a community health service accepts notification that a patient/client requires care/treatment.
Data Element Concept:	Elective care waiting list episode—listing date for care

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	For elective surgery, the listing date is the date on which the patient is added to an elective surgery waiting list. 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.
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.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Listing date for care, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.5 KB) Is used in the formation of Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] Health, Standard 01/03/2005 Is used in the formation of Elective surgery waiting list episode—waiting time (at a census date), total days N[NNN] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Elective surgery waiting times (census data) NMDS Health, Superseded 07/12/2005

Implementation start date: 30/09/2002

Implementation end date: 30/06/2006

Elective surgery waiting times (census data) NMDS 2006-2009 Health, Superseded 03/12/2008

Implementation start date: 30/09/2006

Implementation end date: 31/03/2009

Elective surgery waiting times (census data) NMDS 2009- Health, Standard 03/12/2008

Implementation start date: 30/06/2009

Elective surgery waiting times (removals data) NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2002

Implementation end date: 30/06/2006

Elective surgery waiting times (removals data) NMDS 2006-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2006

Implementation end date: 30/06/2009

Elective surgery waiting times (removals data) NMDS 2009- Health, Standard 03/12/2008

Implementation start date: 01/07/2009

Living arrangement

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—living arrangement, health sector code N
METeOR identifier:	299712
Registration status:	Health, Standard 14/06/2005
Definition:	Whether a person usually resides alone or with others, as represented by a code.
Context:	Client support needs and clinical setting.
Data Element Concept:	Person—living arrangement

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Lives alone
	2	Lives with others
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Collection methods:	This item does not seek to describe the quality of the arrangements but merely the fact of the arrangement. It is recognised that this item may change on a number of occasions during the course of an episode of care.
Comments:	Whether or not a person lives alone is a significant determinant of risk. Living alone may preclude certain treatment approaches (e.g. home dialysis for end-stage renal disease). Social isolation has also been shown to have a negative impact on prognosis in males with known coronary artery disease with several studies suggesting increased mortality rates in those living alone or with no confidant.

Source and reference attributes

Submitting organisation:	Cardiovascular Data Working Group

Relational attributes

Related metadata references:	Supersedes Living arrangement, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.0 KB)
Implementation in Data Set Specifications:	Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006
	Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007
	Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009
	Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Location of impairment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—location of impairment of body structure, code (ICF 2001) N
METeOR identifier:	320177
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The location of a person's impairment in a specified body structure, as represented by a code.
Context:	Human functioning and disability
Data Element Concept:	Person—location of impairment of body structure

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Functioning, Disability and Health 2001
Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
0	More than one region
1	Right
2	Left
3	Both sides
4	Front
5	Back
6	Proximal
7	Distal

Supplementary values:

Value	Meaning
8	Not specified
9	Not applicable

Collection and usage attributes

Guide for use:

This metadata item contributes to the definition of the concept '**Disability**' and gives an indication of the experience of disability for a person.

Impairments of body structure are problems in body structure such as a loss or significant departure from population standards or averages.

Use only one code. Select the one that best describes the situation with this structure. Combinations are not possible.

CODE 0 More than one region (except both sides)

Used when the impairment is present in more than one body location (but not bilaterally see code 3); for example when burn scars affect many areas of skin.

CODE 1 Right

Used when the impairment is present to the right of the midline of the person's body.

CODE 2 Left

Used when the impairment is present to the left of the midline of the person's body.

CODE 3 Both sides (bilateral)

Used when the impairment is two-sided and disposed on opposite sides of the midline axis of the body, for example bilateral joint deformities.

CODE 4 Front

Used when the impairment is present in front of a line passing through the midline of the body when viewed from the side.

CODE 5 Back

Used when the impairment is present behind a line passing through the midline of the body when viewed from the side.

CODE 6 Proximal

Used when the impairment is situated towards the point of origin or attachment, as of a limb or bone (opposed to distal), for example the end of the structure that is closer to the centre of the body.

CODE 7 Distal

Used when the impairment is situated away from the point of origin or attachment, as of a limb or bone (opposed to proximal), for example the end of structure that is further away from the centre of the body.

CODE 8 Not specified

Used when there is an impairment of body structure but the location of the impairment is not recorded.

CODE 9 Not applicable

Used when it is not appropriate to code the location of an impairment of body structure.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin: WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents:

Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website http://www.who.int/classifications/icf/en/
- Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.cfm

Data element attributes

Collection and usage attributes

Guide for use:

This data element is to be used in conjunction with specified body structures, for example, 'impairment of proximal structures related to movement'. This data element may also be used in conjunction with Person—extent of impairment of body structure, code (ICF 2001) N and Person—nature of impairment of body structure, code (ICF 2001).

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references:

See also Person—nature of impairment of body structure, code (ICF 2001) N Health, Standard 29/11/2006, Community services, Standard 16/10/2006

See also Person—extent of impairment of body structure, code (ICF 2001) N Health, Standard 29/11/2006, Community services, Standard 16/10/2006

Implementation in Data Set Specifications:

Body structures cluster Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Lot/section number (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—lot/section identifier, N[X(14)]
Synonymous names:	Australian lot number, section, allotment
METeOR identifier:	270031
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	The unique identifier for the lot/section of the location where a person resides.
Data Element Concept:	Person (address)—lot/section identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	N[X(14)]
Maximum character length:	15

Data element attributes

Collection and usage attributes

Guide for use:	This standard is suitable for postal purposes as well as the physical identification of addresses. A lot number shall be used only when a street number has not been specifically allocated or is not readily identifiable with the property. For identification purposes, the word 'Lot' or 'Section' should precede the lot number and be separated by a space. Examples are as follows: Section 123456 Lot 716 Lot 534A Lot 17 Jones Street
Collection methods:	The lot/section number is positioned before the Street name and type, located in the same line containing the Street name.
Comments:	Lot/section numbers are generally used only until an area has been developed.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Origin:	AS 4590 Interchange of client information, Australia Post Address Presentation Standard
Reference documents:	AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

Related metadata references:	Supersedes Lot/section number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.3 KB)
	Is used in the formation of Person (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005
	Is used in the formation of Person (address)—health address line, text [X(180)] Health, Superseded 04/05/2005
Implementation in Data Set Specifications:	Health care client identification DSS Health, Superseded 03/12/2008
	Health care client identification DSS Health, Standard 03/12/2008
	Health care provider identification DSS Health, Superseded 04/07/2007
	Health care provider identification DSS Health, Superseded 03/12/2008
	Health care provider identification DSS Health, Standard 03/12/2008

Lot/section number (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—lot/section identifier, N[X(14)]
METeOR identifier:	290230
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The unique identifier for the lot/section of the location of an organisation.
Data Element Concept:	Service provider organisation (address)—lot/section identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	N[X(14)]
Maximum character length:	15

Data element attributes

Collection and usage attributes

Guide for use:	This standard is suitable for postal purposes as well as the physical identification of addresses. A lot number shall be used only when a street number has not been specifically allocated or is not readily identifiable with the property. For identification purposes, the word 'Lot' or 'Section' should precede the lot number and be separated by a space. Examples are as follows: Section 123456 Lot 716 Lot 534A Lot 17 Jones Street
Collection methods:	The lot/section number is positioned before the Street name and type, located in the same line containing the Street name.
Comments:	Lot/section numbers are generally used only until an area has been developed.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	AS 4590 Interchange of client information, Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Is used in the formation of Service provider organisation (address) — address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005
Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007
	Health care provider identification DSS Health, Superseded 03/12/2008
	Health care provider identification DSS Health, Standard 03/12/2008

Lower limb amputation due to vascular disease

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—lower limb amputation due to vascular disease, code N
METeOR identifier:	270162
Registration status:	Health, Standard 01/03/2005
Definition:	Whether a person has undergone an amputation of toe, forefoot or leg (above or below knee), due to vascular disease, as represented by a code.
Data Element Concept:	Person—lower limb amputation due to vascular disease

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Lower limb amputation - occurred in the last 12 months
2	Lower limb amputation - occurred prior to the last 12 months
3	Lower limb amputation - occurred both in and prior to the last 12 months
4	No history of lower limb amputation due to vascular disease

Supplementary values:

Value	Meaning
9	Not stated/inadequately described

Collection and usage attributes

Collection methods:	Ask the individual if he/she has had an amputated toe or forefoot or leg (above or below knee), not due to trauma or causes other than vascular disease. If so determine when it was undertaken; within or prior to the last 12 months (or both). Alternatively obtain this information from appropriate documentation.

Data element attributes

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Reference documents:	Duffy MD, John C and Patout MD, Charles A. 1990. Management of the Insensitive Foot in Diabetes: Lessons from Hansen's Disease. Military Medicine, 155:575-579. Edmonds M, Boulton A, Buckenham T et al. Report of the Diabetic Foot and Amputation Group. Diabet Med 1996; 13: S27-42. Sharon R O'Rourke and Stephen Colagiuri: The Lower Limb in People With Diabetes; Content 1997/98 Australian Diabetes Society. Colagiuri S, Colagiuri R, Ward J. National Diabetes Strategy and Implementation Plan. Canberra: Diabetes Australia, 1998.

Relational attributes

Related metadata references:	Supersedes Lower limb amputation due to vascular disease, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.6 KB)
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Superseded 21/09/2005 Diabetes (clinical) DSS Health, Standard 21/09/2005

Lymphovascular invasion

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—lymphovascular invasion, code N
METeOR identifier:	370618
Registration status:	Health, Standard 06/03/2009
Definition:	The presence or absence of the invasion of cancer cells into blood vessel(s) and/or the lymphatic system, as represented by a code.
Data Element Concept:	Person with cancer—lymphovascular invasion

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Present
	2	Absent
	3	Suspicious
Supplementary values:	9	Not stated or unknown

Data element attributes

Collection and usage attributes

Guide for use:	The presence of lymphovascular invasion should be recorded as Code 1, regardless of whether the extent of the invasion is described or not.
Collection methods:	For cancer registries, collection of this data item should only be from notification and pathology reports relating to initial diagnosis and not for recurrent or metastatic disease. If pathology report pertaining to initial diagnosis is for a metastasis, and not the primary tumour, record as 9.
Comments:	Invasion of the lymphatics or blood vessels by cancer cells is an important prognostic factor that indicates that the tumour is likely to spread. This item is included in data items defined for reporting in the pathology reporting guidelines as prepared by the National Breast and Ovarian Cancer Centre and Australian Cancer Network.

Source and reference attributes

Origin:	National Breast and Ovarian Cancer Centre (NBOCC) Australasian Association of Cancer Registries (AACR)

	Australian Institute of Health and Welfare (AIHW)
Reference documents:	National Breast and Ovarian Cancer Centre and Australian Cancer Network. The Pathology reporting of breast cancer. A guide for pathologists, surgeons, radiologists and oncologists (3rd edition). National Breast and Ovarian Cancer Centre, Surry Hills, NSW, 2008.

Relational attributes

Implementation in Data Set Specifications:	Breast cancer (Cancer registries) DSS Health, Standard 06/03/2009

Main language other than English spoken at home

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—main language other than English spoken at home, code (ASCL 2005) NN{NN}
METeOR identifier:	304133
Registration status:	Health, Standard 08/02/2006 Community services, Standard 29/04/2006 Housing assistance, Standard 10/02/2006
Definition:	The language reported by a person as the main language other than English spoken by that person in his/her home (or most recent private residential setting occupied by the person) to communicate with other residents of the home or setting and regular visitors, as represented by a code.
Data Element Concept:	Person—main language other than English spoken at home

Value domain attributes

Representational attributes

Classification scheme:	Australian Standard Classification of Languages 2005
Representation class:	Code
Data type:	Number
Format:	NN{NN}
Maximum character length:	4

Collection and usage attributes

Guide for use:

The Australian Standard Classification of Languages (ASCL) has a three- level hierarchical structure. The most detailed level of the classification consists of base units (languages) which are represented by four-digit codes. The second level of the classification comprises narrow groups of languages (the Narrow Group level), identified by the first two digits. The most general level of the classification consists of broad groups of languages (the Broad Group level) and is identified by the first digit. The classification includes Australian Indigenous languages and sign languages.

For example, the Lithuanian language has a code of 3102. In this case 3 denote that it is an Eastern European language, while 31 denote that it is a Baltic language. The Pintupi Aboriginal language is coded as 8713. In this case 8 denote that it is an Australian Indigenous language and 87 denote that the language is Western Desert language.

Language data may be output at the Broad Group level, Narrow Group level or base level of the classification. If necessary significant Languages within a Narrow Group can be presented separately while the remaining Languages in the Narrow Group

are aggregated. The same principle can be adopted to highlight significant Narrow Groups within a Broad Group.

Data element attributes

Collection and usage attributes

Collection methods:

Recommended question:

Do you/Does the person/Does (name) speak a language other than English at home? (If more than one language, indicate the one that is spoken most often.)

No (English only) ____

Yes, Italian ____

Yes, Greek ____

Yes, Cantonese ____

Yes, Arabic ____

Yes, Mandarin ____

Yes, Vietnamese ____

Yes, Spanish ____

Yes, German ____

Yes, Hindi ____

Yes, Other (please specify) _____

This list reflects the nine most common languages other than English spoken in Australia.

Languages may be added or deleted from the above short list to reflect characteristics of the population of interest.

Alternatively a tick box for 'English' and an 'Other - please specify' response category could be used.

Comments:

This metadata item is consistent with that used in the Australian Census of Population and Housing and is recommended for use whenever there is a requirement for comparison with Census data.

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, Proficiency in spoken English and Country of birth this data element forms the minimum core set of cultural and language indicators recommended by the Australian Bureau of Statistics (ABS).

Data on main language other than English 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.

Source and reference attributes

Origin:

Health Data Standards Committee

National Community Services Data Committee

Australian Bureau of Statistics 2005. Australian Standard Classification of Languages (ASCL) 2005. Cat. no. 1267.0. 2nd Edition, Canberra: ABS. Viewed 29 July 2005.

Relational attributes

Related metadata references:

Supersedes Person—main language other than English spoken at home, code (ASCL 1997) NN{NN} Health, Superseded 08/02/2006, Community services, Superseded 29/04/2006, Housing assistance, Not progressed 13/10/2005

See also Person—preferred language, code (ASCL 2005) NN{NN} Health, Standard 08/02/2006, Community services, Standard 29/04/2006

Main occupation of person

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—occupation (main), code (ANZSCO 1st edition) N[NNN]{NN}
METeOR identifier:	350899
Registration status:	Health, Standard 04/07/2007 Community services, Standard 27/03/2007 Housing assistance, Standard 10/08/2007
Definition:	The job in which the person is principally engaged, as represented by a code.
Data Element Concept:	Person—occupation (main)

Value domain attributes

Representational attributes

Classification scheme:	Australian and New Zealand Standard Classification of Occupations, First edition, 2006
Representation class:	Code
Data type:	Number
Format:	N[NNN]{NN}
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:	A job in any given establishment is a set of tasks designed to be performed by one individual in return for a wage or salary. For persons with more than one job, the main job is the one in which the person works the most hours. Caution is advised in its use with regard to service providers as their activity as a service provider may not be their main occupation.
Collection methods:	This metadata item should only be collected from people whose Labour force status is employed. Occupation is too complex and diverse an issue to fit neatly into any useable small group of categories. Therefore ABS recommend that this metadata item be collected by using the following two open-ended questions: Q1. In the main job held last week (or other recent reference period), what was your/the person's occupation? Q2. What are the main tasks that you/the person usually perform in that occupation? The information gained from these two questions can then be used to select an appropriate code from the ANZSCO at any of the available levels (see Guide for use section).

If only one question is asked, question one should be used. The use of question one only, however, sometimes elicits responses which do not provide a clear occupation title and specification of tasks performed. As a result accurate coding at unit group or occupation level may not be possible.

While agencies are encouraged to use the recommended question described above, it is acknowledged that this is not always possible in practice. For example, where the data collection is a by-product of the provision of a health or community service, the information may be ascertained using different means. However, due to the complexities of the metadata item 'Main occupation of person', this will result in inaccurate information. The recommended question should be used wherever possible.

Comments:

This metadata item may be useful in gaining an understanding of a client's situation and needs. For example, the occupation of a person with a disability may be directly relevant to the type of aids that they require.

National Health Data Dictionary (NHDD) specific:

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.

Source and reference attributes

Origin:

Australian Bureau of Statistics 2006. Australian New Zealand Standard Classification of Occupations (ANZSCO) (Cat. no. 1220.0) (First edition), Viewed 13 March 2007.

Relational attributes

Related metadata references:

Supersedes Person—occupation (main), code (ASCO 2nd edn) N[NNN]{-NN} Health, Superseded 04/07/2007, Community services, Superseded 27/03/2007, Housing assistance, Superseded 10/08/2007

See also Person—labour force status, code N Health, Standard 01/03/2005, Community services, Standard 01/03/2005, Housing assistance, Standard 01/03/2005

Main treatment type for alcohol and other drugs

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—treatment type (main), code N
METeOR identifier:	270056
Registration status:	Health, Standard 01/03/2005
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, as represented by a code.
Data Element Concept:	Episode of treatment for alcohol and other drugs—treatment type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
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

Collection and usage attributes

Guide for use:

CODE 1 Withdrawal management (detoxification)

This code refers to any form of withdrawal management, including medicated and non-medicated, in any delivery setting.

CODE 2 Counselling

This code 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 Rehabilitation

This code refers to an intensive treatment program that integrates a range of services and therapeutic activities that may include counselling, 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. Counselling that is included within an overall rehabilitation program should be coded to Code 3 for Rehabilitation, not to Code 2 as a separate treatment episode for counselling.

CODE 4 Pharmacotherapy

Refers to pharmacotherapies that include those used as maintenance therapies (e.g. naltrexone, buprenorphine, and methadone treatment) and those used as relapse prevention. Use Code 1 (withdrawal management) where a pharmacotherapy is used solely for withdrawal. Note collection exclusions: excludes treatment episodes for clients who are on an opioid pharmacotherapy maintenance program and are not receiving any other form of treatment.

CODE 5 Support and case management only

Refers to when there is no treatment provided to the client other than support and case management (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 Information and education only

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 Assessment only

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.

Data element attributes

Collection and usage attributes

Guide for use:

Only one code to be selected.

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.

Comments:

Information about treatment provided is of fundamental importance to service delivery and planning.

Source and reference attributes

Submitting organisation: Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references: Supersedes Main treatment type for alcohol and other drugs, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.9 KB)

Implementation in Data Set Specifications: Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Alcohol and other drug treatment services NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Major diagnostic category

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—major diagnostic category, code (AR-DRG v 6) NN
METeOR identifier:	391298
Registration status:	Health, Standard 22/12/2009
Definition:	The category into which the patient's diagnosis and the associated Australian refined diagnosis related group (ARDG) falls, as represented by a code.
Data Element Concept:	Episode of admitted patient care—major diagnostic category

Value domain attributes

Representational attributes

Classification scheme:	Australian Refined Diagnosis Related Groups version 6
Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Data element attributes

Collection and usage attributes

Comments:	This metadata item has been created to reflect the development of Australian refined diagnosis related groups (AR-DRGs) (as defined in the metadata item Episode of admitted patient care—diagnosis related group, code (AR-DRG v 6) ANNA) by the Commonwealth Department of Health and Ageing. Due to the modifications in the diagnosis related group logic for the AR-DRGs, 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.

Source and reference attributes

Submitting organisation:	Department of Health and Ageing, Acute and Co-ordinated Care Branch

Relational attributes

Related metadata references:	See also Episode of admitted patient care—diagnosis related group, code (AR-DRG v 6) ANNA Health, Standard 22/12/2009 Supersedes Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN Health, Superseded 22/12/2009

Is formed using Episode of care—mental health legal status, code N Health, Standard 01/03/2005

Is formed using Episode of admitted patient care—number of leave days, total N[NN] Health, Standard 01/03/2005

Is formed using Person—weight (measured), total grams NNNN Health, Standard 01/03/2005

Is formed using Episode of admitted patient care—intended length of hospital stay, code N Health, Standard 01/03/2005

Is formed using Episode of admitted patient care—separation mode, code N Health, Standard 01/03/2005

Is formed using Episode of admitted patient care—separation date, DDMMYYYY Health, Standard 01/03/2005

Is formed using Person—sex, code N Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 10/02/2006

Is formed using Episode of admitted patient care—admission date, DDMMYYYY Health, Standard 01/03/2005

Is formed using Person—date of birth, DDMMYYYY Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 20/06/2005

Is formed using Episode of care—principal diagnosis, code (ICD-10-AM 7th edn) ANN{.N[N]} Health, Standard 22/12/2009

Is formed using Episode of care—additional diagnosis, code (ICD-10-AM 7th edn) ANN{.N[N]} Health, Standard 22/12/2009

Is formed using Episode of admitted patient care—procedure, code (ACHI 7th edn) NNNNN-NN Health, Standard 22/12/2009

Implementation in Data Set Specifications:

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Admitted patient mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Marital status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—marital status, code N
METeOR identifier:	291045
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 10/02/2006
Definition:	A person's current relationship status in terms of a couple relationship or, for those not in a couple relationship, the existence of a current or previous registered marriage, as represented by a code.
Data Element Concept:	Person—marital status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Never married
2	Widowed
3	Divorced
4	Separated
5	Married (registered and de facto)

Supplementary values:

6	Not stated/inadequately described

Collection and usage attributes

Guide for use: Refers to the current marital status of a person.

CODE 2 Widowed

This code usually refers to registered marriages but when self reported may also refer to de facto marriages.

CODE 4 Separated

This code refers to registered marriages but when self reported may also refer to de facto marriages.

CODE 5 Married (registered and de facto)

Includes people who have been divorced or widowed but have since re-married, and should be generally accepted as applicable to all de facto couples, including of the same sex.

CODE 6 Not stated/inadequately described

This code is not for use on primary collection forms. It is

primarily for use in administrative collections when transferring data from data sets where the item has not been collected.

Source and reference attributes

Origin: The ABS standards for the collection of Social and Registered marital status appear on the ABS Website. Australian Bureau of Statistics. Family, household and income unit variables. Cat. no. 1286.0. Canberra: ABS.

Data element attributes

Collection and usage attributes

Collection methods: This metadata item collects information on social marital status. The recommended question module is:

Do you/Does the person usually live with a partner in a registered or de facto marriage?

Yes, in a registered marriage

Yes, in a de facto marriage

No, never married

No, separated

No, divorced

No, widowed

It should be noted that information on marital status is collected differently by the ABS, using a set of questions. However, the question outlined above is suitable and mostly sufficient for use within the health and community services fields. See Source document for information on how to access the ABS standards.

While agencies are encouraged to use the recommended question described above, it is acknowledged that this is not always possible in practice. For example, where the data collection is a by-product of the provision of a health or community service, the information may be ascertained using different means. However, the recommended question should be used wherever practically possible.

Comments: The ABS standards identify two concepts of marital status:

- Registered marital status - defined as whether a person has, or has had, a registered marriage;
- Social marital status - based on a person's living arrangement (including de facto marriages), as reported by the person.

It is recommended that the social marital status concept be collected when information on social support/home arrangements is sought, whereas the registered marital status concept need only be collected where it is specifically required for the purposes of the collection.

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

arrangement and other data elements need to be formulated to capture this information.

Source and reference attributes

Origin: National Health Data Standards Committee

National Community Services Data Committee

Relational attributes

Related metadata references: Supersedes Person—marital status, code N Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005

Implementation in Data Set Specifications:

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Community mental health care 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Community mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Community mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Community mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Community mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Computer Assisted Telephone Interview demographic module DSS Health, Superseded 03/12/2008

Computer Assisted Telephone Interview demographic module DSS Health, Standard 03/12/2008

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Residential mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Residential mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Maternal medical conditions

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female (pregnant)—maternal medical condition, code (ICD-10-AM 7th edn) ANN{.N[N]}
METeOR identifier:	391328
Registration status:	Health, Standard 22/12/2009
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, as represented by a code.
Context:	Perinatal statistics
Data Element Concept:	Female (pregnant)—maternal medical condition

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Data element attributes

Collection and usage attributes

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.
Comments:	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 fetus and perinatal morbidity.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Female (pregnant)—maternal medical condition, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009

Maximum stenosis coronary artery

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—maximum stenosis coronary artery, percentage N[NN]
METeOR identifier:	344335
Registration status:	Health, Standard 01/10/2008
Definition:	The percentage of stenosis at its maximal point in a person's coronary artery.
Data Element Concept:	Person—maximum stenosis coronary artery

Value domain attributes

Representational attributes

Representation class:	Percentage
Data type:	Number
Format:	N[NN]
Maximum character length:	3

Supplementary values:

Value	Meaning
999	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

Stenosis represents the percentage of occlusion, from 0 to 100%, associated with the identified vessel system. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the 'normal' vessel proximal and distal to the lesion.

In instances where multiple lesions are present in a coronary artery, record the highest percentage stenosis noted.

Collection methods: This data is derived from visual recording by the physician reporting the angiogram.

Relational attributes

Related metadata references: See also Person—coronary artery stenosis location, code N Health, Standard 01/10/2008

Implementation in Data Set Specifications: Coronary artery cluster Health, Standard 01/10/2008

Medicare card number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—government funding identifier, Medicare card number N(11)
METeOR identifier:	270101
Registration status:	Health, Standard 01/03/2005 Community services, Recorded 27/03/2007
Definition:	Person identifier, allocated by the Health Insurance Commission to eligible persons under the Medicare scheme, that appears on a Medicare card.
Context:	Medicare utilisation statistics. Persons eligible for Medicare services.
Data Element Concept:	Person—government funding identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	Number
Format:	N(11)
Maximum character length:	11

Collection and usage attributes

Guide for use:	Full Medicare number for an individual (i.e. family number plus person (individual reference) number).
Comments:	The Medicare card number is printed on a Medicare card and is used to access Medicare records for an eligible person. Up to 9 persons can be included under the one Medicare card number with up to five persons appearing on one physical card. Persons grouped under one Medicare card number are often a family, however, there is no requirement for persons under the same Medicare card number to be related. A person may be shown under separate Medicare card numbers where, for example, a child needs to be included on separate Medicare cards held by their parents. As a person can be identified on more than one Medicare card this is not a unique identifier for a person.

Data element attributes

Collection and usage attributes

Guide for use:	The Medicare card number should only be collected from persons eligible to receive health services that are to be funded by the Commonwealth government. The number should be reported to

	the appropriate government agency to reconcile payment for the service provided. The data should not be used by private sector organisations for any other purpose unless specifically authorised by law. For example, data linkage should not be carried out unless specifically authorised by law.
Comments:	Note: Veterans may have a Medicare card number and a Department of Veterans' Affairs (DVA) number or only a DVA number.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS5017 Health care client identification

Relational attributes

Related metadata references:	Supersedes Medicare card number, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.6 KB)
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005
	Cancer (clinical) DSS Health, Superseded 06/03/2009
	Cancer (clinical) DSS Health, Superseded 22/12/2009
	Cancer (clinical) DSS Health, Standard 22/12/2009
	Health care client identification Health, Superseded 04/05/2005
	Health care client identification DSS Health, Superseded 03/12/2008
	Health care client identification DSS Health, Standard 03/12/2008

Medicare eligibility status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—eligibility status, Medicare code N
METeOR identifier:	351922
Registration status:	Health, Standard 04/07/2007
Definition:	An indicator of a person's eligibility for Medicare at the time of the episode of care, as specified under the Commonwealth Health Insurance Act 1973, as represented by a code.
Context:	Admitted patient care: To facilitate analyses of hospital utilisation and policy relating to health care financing.
Data Element Concept:	Person—eligibility status

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Eligible
	2	Not eligible
Supplementary values:	9	Not stated/unknown

Data element attributes

Collection and usage attributes

Guide for use: Eligible persons are

- Permanent residents of Australia
- Persons who have an application for permanent residence (not an aged parent visa), and have either:

- a spouse, parent or child who is an Australian citizen or permanent resident, OR

- authority from Department of Immigration and Multicultural and Indigenous Affairs to work

- Foreign spouses of Australian residents:

- must have an application for permanent residence, as above

- Asylum seekers who have been issued with valid temporary visas. The list of visas is subject to changes which may be applied by the Department of Immigration and Multicultural Affairs.

- American Fulbright scholars studying in Australia (but not their dependents)
- Diplomats and their dependants from reciprocal health countries (excluding New Zealand and Norway) have full access to Medicare without the restrictions for American Fulbright scholars.

Reciprocal health care agreements

Residents of countries with whom Australia has Reciprocal health care agreements are also eligible under certain circumstances. Australia has Reciprocal Health Care Agreements with Ireland, Italy, Finland, Malta, the Netherlands, New Zealand, Norway, Sweden and the United Kingdom. These Agreements give visitors from these countries access to Medicare and the Pharmaceutical Benefits Scheme for the treatment of an illness or injury which occurs during their stay, and which requires treatment before returning home (that is, these Agreements cover immediately necessary medical treatment, elective treatment is not covered). The Agreements provide for free accommodation and treatment as public hospital services, but do not cover treatment as a private patient in any kind of hospital.

– The Agreements with Finland, Italy, Malta, the Netherlands, Norway, Sweden and the United Kingdom provide free care as a public patient in public hospitals, subsidised out-of-hospital medical treatment under Medicare, and subsidised medicines under the Pharmaceutical Benefits Scheme.

– The Agreements with New Zealand and Ireland provide free care as a public patient in public hospitals and subsidised medicines under the Pharmaceutical Benefits Scheme, but do not cover out-of-hospital medical treatment.

– Visitors from Italy and Malta are covered for a period of six months from the date of arrival in Australia only.

Eligible patients may elect to be treated as either a public or a private patient.

A newborn will usually take the Medicare eligibility status of the mother. However, the eligibility status of the father will be applied to the newborn if the baby is not eligible solely by virtue of the eligibility status of the mother.

For example, if the mother of a newborn is an ineligible person but the father is eligible for Medicare, then the newborn will be eligible for Medicare.

Not eligible/ineligible: means any person who is not Medicare eligible. Ineligible patients may not elect to be treated as a public patient.

Prisoners are ineligible for Medicare, under Section 19 (2) of the Health Insurance Act 1973.

Relational attributes

Related metadata references: Supersedes Person—eligibility status, Medicare code N Health, Superseded 04/07/2007

Mental health legal status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—mental health legal status, code N
METeOR identifier:	270351
Registration status:	Health, Standard 01/03/2005
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 admitted patient care, an episode of residential care or treatment of a patient/client by a community based service during a reporting period, as represented by a code.
Data Element Concept:	Episode of care—mental health legal status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Involuntary patient
2	Voluntary patient

Supplementary values:

3	Not permitted to be reported under legislative arrangements in the jurisdiction

Collection and usage attributes

Guide for use:

CODE 1 Involuntary patient

Involuntary patient 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.

CODE 2 Voluntary patient

Voluntary patient to be used for reporting to the NMDS-Community mental health care, where applicable.

CODE 3 Not permitted to be reported under legislative arrangements in the jurisdiction

Not permitted to be reported under legislative arrangements in the jurisdiction, is to be used for reporting to the National Minimum Data Set - Community mental health care, where applicable.

Data element attributes

Collection and usage attributes

Guide for use:

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.

Similarly, the mental health legal status of residents treated within residential care services may change on multiple occasions throughout the episode of residential care or residential stay.

Collection methods:

Admitted patients to be reported as involuntary if the patient is involuntary at any time during the episode of care.

Residents in **residential mental health services** to be reported as involuntary if the resident is involuntary at any time during the episode of residential care.

Patients of ambulatory mental health care services to be reported as involuntary if the patient is involuntary at the time of a service contact.

Source and reference attributes

Origin:

National Health Data Committee

Relational attributes

Related metadata references:

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v 6) NN Health, Standard 22/12/2009

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v 6) ANNA Health, Standard 22/12/2009

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA Health, Superseded 22/12/2009

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN Health, Superseded 22/12/2009

Implementation in Data Set Specifications:

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Community mental health care 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Community mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Community mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Community mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Community mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Residential mental health care NMDS 2009-2010 Health,

Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Residential mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Mental health service contact date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Mental health service contact—service contact date, DDMMYYYY
METeOR identifier:	295481
Registration status:	Health, Standard 08/12/2004
Definition:	The date of each mental health service contact between a health service provider and patient/client.
Data Element Concept:	Mental health service contact—service contact date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Collection methods:	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. For collection from community based (ambulatory and non-residential) agencies.
Comments:	The service contact is required for clinical audit and other quality assurance purposes.

Relational attributes

Implementation in Data Set Specifications:	Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Community mental health care NMDS 2006-2007 Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Community mental health care NMDS 2007-2008 Health,

Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Community mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Community mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Mental health service contact duration

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Mental health service contact—service contact duration, total minutes NNN
METeOR identifier:	286682
Registration status:	Health, Standard 08/12/2004
Definition:	The time from the start to finish of a service contact.
Data Element Concept:	Mental health service contact—mental health service contact duration

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NNN
Maximum character length:	3

Data element attributes

Collection and usage attributes

Guide for use:	For group sessions the time for the patient/client in the session is recorded for each patient/client, regardless of the number of patients/clients or third parties participating or the number of service providers providing the service. Writing up details of service contacts is not to be reported as part of the duration, except if during or contiguous with the period of patient/client or third party participation. Travel to or from the location at which the service is provided, for example to or from outreach facilities or private homes, is not to be reported as part of the duration of the service contact.
Comments:	Counting the duration for each patient/client in a group session means that this data element cannot be used to measure the duration of service contacts from the perspective of the service provider.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:	Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006

Community mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Community mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Community mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Community mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Mental health service contact—patient/client participation indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Mental health service contact—patient/client participation indicator, yes/no code N
METeOR identifier:	286859
Registration status:	Health, Standard 08/12/2004
Definition:	Whether the patient/client has participated in a service contact, as represented by a code.
Data Element Concept:	Mental health service contact—patient/client participation indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

Service contacts are not restricted to in-person communication but can include telephone, video link or other forms of direct communication.

- Code 1 is to be used for service contacts between a specialised mental health service provider and the patient/client in whose clinical record the service contact would normally warrant a dated entry, where the patient/client is participating.
- Code 2 is to be used for service contacts between a specialised mental health service provider and a third party(ies) where the patient/client, in whose clinical record the service contact would normally warrant a dated entry, is not participating.

Relational attributes

Implementation in Data Set Specifications:

Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Community mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Community mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Community mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Community mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Mental health service contact—session type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Mental health service contact—session type, code N
METeOR identifier:	286832
Registration status:	Health, Standard 08/12/2004
Definition:	Whether a service contact is provided for one or more patient(s)/client(s), as represented by a code.
Data Element Concept:	Mental health service contact—session type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Individual session
2	Group session

Data element attributes

Collection and usage attributes

Guide for use:

A service contact is regarded as an individual session where the service is provided for one patient/client with or without third party involvement.

A service contact is regarded as a group session where two or more patients/clients are participating in the service contact with or without third parties and the nature of the service would normally warrant dated entries in the clinical records of the patients/clients in question.

A service contact is also regarded as a group session where third parties for two or more patients/clients are participating in the service contact without the respective patients/clients and the nature of the service would normally warrant dated entries in the clinical records of the patients/clients in question.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:	Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Community mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Community mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Community mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Community mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Mental health services grants to non-government organisations by non-health departments

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	State or Territory Government—mental health services grants to non-government organisations by non-health departments, total Australian currency N[N(8)]
METeOR identifier:	298940
Registration status:	Health, Standard 07/12/2005
Definition:	Total amount of money in the form of grants made by state or territory departments outside the health portfolios directly to non-government organisations specifically for the provision of mental health activities or programs (other than staffed residential services).
Data Element Concept:	State or Territory Government—mental health services grants to non-government organisations by non-health departments

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Where the exact dollar amount is unable to be provided an estimate should be derived from information available to the state or territory health department.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Method of birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—birth method, code N
METeOR identifier:	295349
Registration status:	Health, Standard 06/09/2006
Definition:	The method of complete expulsion or extraction from its mother of a product of conception in a birth event, as represented by a code.
Data Element Concept:	Birth event—birth method

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Vaginal - non-instrumental
2	Vaginal - forceps
4	Caesarean section
5	Vaginal - vacuum extraction

Supplementary values:

9	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Data element attributes

Collection and usage attributes

Guide for use:	In a vaginal breech with forceps to the after coming head, code as vaginal - forceps. In a vaginal breech that has been manually rotated, code as vaginal - non-instrumental. Where forceps/vacuum extraction are used to assist the extraction of the baby at caesarean section, code as caesarean section. Where a hysterotomy is performed to extract the baby, code as caesarean section.
Collection methods:	In the case of multiple births, method of birth should be recorded for each baby born.

Comments: Note: Code 3, which had a meaning in previous versions of the data standard is no longer used. As is good practice, the code will not be reused.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Birth event—delivery method, code N Health, Superseded 06/09/2006

Implementation in Data Set Specifications:

Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Perinatal NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Method of use for principal drug of concern

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Client—method of drug use (principal drug of concern), code N
METeOR identifier:	270111
Registration status:	Health, Standard 01/03/2005
Definition:	The client's self-reported usual method of administering the principal drug of concern, as represented by a code.
Data Element Concept:	Client—method of drug use (principal drug of concern)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Ingests
	2	Smokes
	3	Injects
	4	Sniffs (powder)
	5	Inhales (vapour)
	6	Other
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation:	Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references:

Supersedes Method of use for principal drug of concern, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Implementation in Data Set Specifications:

Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Alcohol and other drug treatment services NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Microalbumin level—albumin/creatinine ratio (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—microalbumin level (measured), albumin/creatinine ratio N[NN].N
METeOR identifier:	270339
Registration status:	Health, Standard 01/03/2005
Definition:	A person's microalbumin level, measured as an albumin/creatinine ratio.
Data Element Concept:	Person—microalbumin level

Value domain attributes

Representational attributes

Representation class:	Ratio
Data type:	Number
Format:	N[NN].N
Maximum character length:	4

Supplementary values:

Value	Meaning
999.9	Not stated/inadequately described

Unit of measure:	Milligram per millimole (mg/mmol)
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Collection methods:

Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.

Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.

As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate, and if the albumin/creatinine ratio is found to be greater than 3.5 mg/mmol then a timed overnight sample should be obtained for estimation of the albumin excretion rate.

Test for albuminuria by measuring microalbumin in timed or first morning urine sample.

The results considered elevated are

- spot urine 30 to 300 mg/L; or
- timed urine (24 hour collection) 20 to 200 µg/min.

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references:	See also Laboratory standard—upper limit of normal range for microalbumin, albumin/creatinine ratio N[NN].N Health, Standard 01/03/2005
	Supersedes Microalbumin/protein - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB)
	Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.3 KB)
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Superseded 21/09/2005
	Diabetes (clinical) DSS Health, Standard 21/09/2005

Microalbumin level—micrograms per minute (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—microalbumin level (measured), total micrograms per minute N[NNN].N
METeOR identifier:	270336
Registration status:	Health, Standard 01/03/2005
Definition:	A person's microalbumin level measured in microgram per minute (µg/min).
Data Element Concept:	Person—microalbumin level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN].N
Maximum character length:	5
Supplementary values:	Value: 9999.9 — Meaning: Not stated/inadequately described
Unit of measure:	Microgram per minute (µg/min)
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Collection methods:

Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.

Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.

As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate.

Test for albuminuria by measuring microalbumin in timed or first morning urine sample.

The results considered elevated are

- spot urine 30 to 300mg/L; or
- timed urine (24 hr collection) 20 to 200 µg/min.

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references:	Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.3 KB) Supersedes Microalbumin/protein - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB) See also Laboratory standard—upper limit of normal range for microalbumin, total micrograms per minute N[NN].N Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Superseded 21/09/2005 Diabetes (clinical) DSS Health, Standard 21/09/2005

Microalbumin level—milligrams per 24 hour (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—microalbumin level (measured), total milligrams per 24 hour N[NNN].N
METeOR identifier:	270337
Registration status:	Health, Standard 01/03/2005
Definition:	A person's microalbumin level measured in milligrams per 24 hours.
Data Element Concept:	Person—microalbumin level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN].N
Maximum character length:	5

Supplementary values:

Value	Meaning
9999.9	Not stated/inadequately described

Unit of measure:	Milligram per 24-hour period (mg/24h)
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Collection methods:

Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.

Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.

As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate.

Test for albuminuria by measuring microalbumin in timed or first morning urine sample.

The results considered elevated are

- spot urine 30 to 300mg/L; or
- timed urine (24 hr collection) 20 to 200 ug/min.

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references:	Supersedes Microalbumin/protein - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB) Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.3 KB) See also Laboratory standard—upper limit of normal range for microalbumin, total milligrams per 24 hour N[NN].N Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Superseded 21/09/2005 Diabetes (clinical) DSS Health, Standard 21/09/2005

Microalbumin level—milligrams per litre (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—microalbumin level (measured), total milligrams per litre N[NNN].N
METeOR identifier:	270335
Registration status:	Health, Standard 01/03/2005
Definition:	A person's microalbumin level measured in milligrams per litre (mg/L).
Data Element Concept:	Person—microalbumin level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN].N
Maximum character length:	5

Supplementary values:

Value	Meaning
9999.9	Not stated/inadequately described

Unit of measure:	Milligram per litre (mg/L)
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Collection methods:

Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.

Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.

As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate.

Test for albuminuria by measuring microalbumin in timed or first morning urine sample.

The results considered elevated are:

- spot urine 30 to 300mg/L; or
- timed urine (24 hr collection) 20 to 200 ug/min.

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references:	Supersedes Microalbumin/protein - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB) Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.3 KB) See also Laboratory standard—upper limit of normal range for microalbumin, total milligrams per litre N[NN].N Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Superseded 21/09/2005 Diabetes (clinical) DSS Health, Standard 21/09/2005

Microalbumin level—upper limit of normal range (albumin/creatinine ratio)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for microalbumin, albumin/creatinine ratio N[NN].N
Synonymous names:	Albumin/creatinine ratio
METeOR identifier:	270344
Registration status:	Health, Standard 01/03/2005
Definition:	The laboratory standard for the value of microalbumin measured as an albumin/creatinine ratio that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for microalbumin

Value domain attributes

Representational attributes

Representation class:	Ratio
Data type:	Number
Format:	N[NN].N
Maximum character length:	4

Supplementary values:

Value	Meaning
999.9	Not stated/inadequately described

Unit of measure:	Milligram per millimole (mg/mmol)
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the microalbumin normal reference range for the laboratory.
Collection methods:	Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay. Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority. As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate and if the albumin/creatinine ratio is found to be greater than 3.5mg/mmol

then a timed overnight sample should be obtained for estimation of the albumin excretion rate.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references: Supersedes Microalbumin - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.8 KB)

Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.3 KB)

See also Person—microalbumin level (measured), albumin/creatinine ratio N[NN].N Health, Standard 01/03/2005

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Microalbumin level—upper limit of normal range (micrograms per minute)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for microalbumin, total micrograms per minute N[NN].N
METeOR identifier:	270341
Registration status:	Health, Standard 01/03/2005
Definition:	The laboratory standard for the value of microalbumin measured in micrograms per minute (µg/min), that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for microalbumin

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN].N
Maximum character length:	4

Supplementary values:

Value	Meaning
999.9	Not stated/inadequately described

Unit of measure:	Microgram per minute (µg/min)
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the microalbumin normal reference range for the laboratory.
Collection methods:	Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay. Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority. As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate.

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group

Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references:	Supersedes Microalbumin - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.8 KB)
	Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.3 KB)
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Superseded 21/09/2005
	Diabetes (clinical) DSS Health, Standard 21/09/2005

Microalbumin level—upper limit of normal range (milligrams per 24 hour)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for microalbumin, total milligrams per 24 hour N[NN].N
METeOR identifier:	270343
Registration status:	Health, Standard 01/03/2005
Definition:	The laboratory standard for the value of microalbumin measured in milligrams per 24 hour, that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for microalbumin

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN].N
Maximum character length:	4
Supplementary values:	Value: 999.9 — Meaning: Not stated/inadequately described
Unit of measure:	Milligram per 24-hour period (mg/24h)
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the microalbumin normal reference range for the laboratory.
Collection methods:	Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay. Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority. As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate.

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group

Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:	Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.3 KB)
	Supersedes Microalbumin - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.8 KB)
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Superseded 21/09/2005
	Diabetes (clinical) DSS Health, Standard 21/09/2005

Microalbumin level—upper limit of normal range (milligrams per litre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for microalbumin, total milligrams per litre N[NN].N
METeOR identifier:	270334
Registration status:	Health, Standard 01/03/2005
Definition:	The laboratory standard for the value of microalbumin measured in milligrams per litre (mg/L), that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for microalbumin

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN].N
Maximum character length:	4

Supplementary values:

Value	Meaning
999.9	Not stated/inadequately described

Unit of measure:	Milligram per litre (mg/L)
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the microalbumin normal reference range for the laboratory.
Collection methods:	Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay. Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority. As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate.

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references: Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.3 KB)

Supersedes Microalbumin - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.8 KB)

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Minutes of operating theatre time

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Admitted patient hospital stay—operating theatre time, total minutes NNNN
METeOR identifier:	270350
Registration status:	Health, Standard 01/03/2005
Definition:	Total time, in minutes, spent by a patient in operating theatres during current episode of hospitalisation.
Data Element Concept:	Admitted patient hospital stay—operating theatre time

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NNNN
Maximum character length:	4
Unit of measure:	Minute (m)

Collection and usage attributes

Collection methods:	Right justified, zero filled.

Data element attributes

Collection and usage attributes

Comments:	This metadata 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 metadata item has not been accepted for inclusion in the National Minimum Data Set (NMDS) - Admitted patient care.

Source and reference attributes

Origin:	Health Data Standards Committee

Relational attributes

Related metadata references:	Supersedes Minutes of operating theatre time, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.3 KB)

Mode of admission

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—admission mode, code N
METeOR identifier:	269976
Registration status:	Health, Standard 01/03/2005
Definition:	The mechanism by which a person begins an episode of care, as represented by a code.
Data Element Concept:	Episode of admitted patient care—admission mode

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Admitted patient transferred from another hospital
2	Statistical admission - episode type change
3	Other

Collection and usage attributes

Guide for use:

CODE 2 Statistical admission - episode type change

Use this code where a new episode of care is commenced within the same hospital stay.

CODE 3 Other

Use this code for all planned admissions and unplanned admissions (except transfers into the hospital from another hospital).

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Mode of admission, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)
Implementation in Data Set Specifications:	Admitted patient care NMDS Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Admitted patient palliative care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient palliative care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient palliative care NMDS 2007-08 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient palliative care NMDS 2008-09 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient palliative care NMDS 2009-10 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient palliative care NMDS 2010-11 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Mode of separation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—separation mode, code N
METeOR identifier:	270094
Registration status:	Health, Standard 01/03/2005
Definition:	Status at **separation** of person (discharge/transfer/death) and place to which person is released, as represented by a code.
Data Element Concept:	Episode of admitted patient care—separation mode

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
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))

Collection and usage attributes

Guide for use:

CODE 4 Discharge/transfer to other health care accommodation (includes mothercraft hospitals)

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.

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Mode of separation, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.3 KB)

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v 6) NN Health, Standard 22/12/2009

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v 6) ANNA Health, Standard 22/12/2009

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA Health, Superseded 22/12/2009

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN Health, Superseded 22/12/2009

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Admitted patient palliative care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient palliative care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient palliative care NMDS 2007-08 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient palliative care NMDS 2008-09 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient palliative care NMDS 2009-10 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient palliative care NMDS 2010-11 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Month and year of birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—date of birth, MMYYYY
METeOR identifier:	375191
Registration status:	Health, Standard 10/12/2009
Definition:	The month and year of birth of the person.
Data Element Concept:	Person—date of birth

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	MMYYYY
Maximum character length:	6

Data element attributes

Collection and usage attributes

Collection methods:	In some collections data may be reported in DDMMYYYY format. Agencies providing data to other agencies may choose to provide the abbreviated version (MMYYYY) to protect the privacy of respondents.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	National Health Data Committee
	National Community Services Data Committee
Reference documents:	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia
	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references:	See also Person—age, total years N[NN] Health, Standard 08/02/2006, Community services, Standard 29/04/2006, Housing assistance, Standard 10/02/2006
	See also Date—accuracy indicator, code AAA Health, Standard 04/05/2005, Community services, Standard 30/09/2005
Implementation in Data Set Specifications:	Registered chiropractic labour force DSS Health, Standard 10/12/2009
	Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009

Registered medical professional labour force DSS Health, Standard 10/12/2009

Registered midwifery labour force DSS Health, Standard 10/12/2009

Registered nursing professional labour force DSS Health, Standard 10/12/2009

Registered optometry labour force DSS Health, Standard 10/12/2009

Registered osteopathy labour force DSS Health, Standard 10/12/2009

Registered pharmacy labour force DSS Health, Standard 10/12/2009

Registered physiotherapy labour force DSS Health, Standard 10/12/2009

Registered podiatry labour force DSS Health, Standard 10/12/2009

Registered psychology labour force DSS Health, Standard 10/12/2009

Morphology of cancer

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—morphology of cancer, code (ICDO-3) NNNN/N
METeOR identifier:	370023
Registration status:	Health, Standard 06/03/2009
Definition:	The histological classification of the cancer tissue (histopathological type) and a description of the course of development that a tumour is likely to take: benign or malignant (behaviour), as represented by a code.
Data Element Concept:	Person with cancer—morphology of cancer

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Diseases for Oncology 3rd edition
Representation class:	Code
Data type:	Number
Format:	NNNN/N
Maximum character length:	5

Collection and usage attributes

Guide for use:

ICDO morphology describes histology and behaviour as separate variables, recognising that there are a large number of possible combinations.

In ICDO, morphology is a 4-digit number ranging from 8000 to 9989, and behaviour is a single digit which can be 0, 1, 2, 3, 6 or 9.

Record morphology codes in accordance with ICDO coding standards. Use the 5th-digit to record behaviour. The 5th-digit behaviour code numbers used in ICDO are listed below:

0 Benign

1 Uncertain whether benign or malignant

- borderline malignancy
- low malignant potential

2 Carcinoma in situ

- intraepithelial
- non-infiltrating
- non-invasive

3 Malignant, primary site

6 Malignant, metastatic site

- malignant, secondary site

9 Malignant, uncertain whether primary or metastatic site

Source and reference attributes

Origin: International Classification of Diseases for Oncology, Third Edition (ICDO-3)

Data element attributes

Collection and usage attributes

Collection methods:

Cancer registry use:

Collection of this data item should only be from notification and pathology reports relating to initial diagnosis and not for recurrent or metastatic disease.

Morphology information should be obtained from a pathology report or pathology system, and recorded with/on the patient's medical record and/or the hospital's patient administration system. Additional information may also be sought from the patient's attending clinician or medical practitioner.

If the morphology differs on multiple pathology reports for the same tumour, use the value from the most representative tumour specimen examined. For example, if tumour is described as ductal on core biopsy but undifferentiated carcinoma on the excision specimen the morphology would be coded as undifferentiaited carcinoma (a lower code) which has a less favourable diagnosis.

Hospital morbidity use:

In hospitals, the morphology code is modified for use with ICD-10-AM. The morphology code consists of histologic type (4 digits) and behaviour code (1 digit) ranging from 8000/0 to 9989/9.

Source and reference attributes

Origin:

World Health Organization

New South Wales Health Department

State and Territory Cancer Registries

Reference documents:

New South Wales Inpatient Statistics Collection Manual, 2000/2001

Esteban D, Whelan S, Laudico A and Parkin DM editors. International Agency for Research on Cancer World Health Organization and International Association of Cancer Registries: Manual for cancer registry personnel. IARC Technical Report No 10. Lyon: IARC,1995

Relational attributes

Related metadata references:

Supersedes Person with cancer—morphology of cancer, code (ICDO-3) NNNN/N Health, Superseded 06/03/2009

Implementation in Data Set Specifications:

Breast cancer (Cancer registries) DSS Health, Standard 06/03/2009

Cancer (clinical) DSS Health, Superseded 22/12/2009

Cancer (clinical) DSS Health, Standard 22/12/2009

Most common service delivery setting

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—most common service delivery setting, code N
METeOR identifier:	297708
Registration status:	Health, Standard 05/12/2007
Definition:	The setting in which the service provider organisation most commonly delivers services, as represented by a code.
Data Element Concept:	Service provider organisation—most common service delivery setting

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Mostly community-based setting
2	Mostly inpatient setting
3	Similar proportion in both settings

Collection and usage attributes

Collection methods:	Record only one code.

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Mostly community based setting

During the past 12 months, more than 60% of service delivery time was estimated to have been spent on delivering services to, and on behalf of, clients in community settings. This includes residential settings such as private residences (including caravans, mobile homes, houseboats or units in a retirement village), residential aged care facilities, prisons, and community living environments (including group homes); and non-residential settings such as day respite centres or day centres. It includes hospital outreach services and outpatient settings where these are delivered in the community setting.

CODE 2 Mostly inpatient setting

During the past 12 months, more than 60% of service delivery time was estimated to have been spent on delivering services to,

and on behalf of, clients in inpatient settings. This includes hospitals, hospices or admitted patient settings. It excludes services delivered in outpatient settings and hospital outreach services delivered in the community setting.

CODE 3 Similar level in both settings

During the past 12 months, a similar proportion of service delivery time (between 40-60%) was estimated to have been spent on delivering services in community and inpatient settings.

Collection methods: Record only one code.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications: Palliative care performance indicators DSS Health, Standard 05/12/2007

Most valid basis of diagnosis of cancer

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—most valid basis of diagnosis of a cancer, code N
METeOR identifier:	270181
Registration status:	Health, Standard 01/03/2005
Definition:	The most valid basis of diagnosis of cancer, as represented by a code.
Data Element Concept:	Person with cancer—most valid basis of diagnosis of a cancer

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
0	Death certificate only: Information provided is from a death certificate
1	Clinical: Diagnosis made before death, but without any of the following (codes 2-7)
2	Clinical investigation: All diagnostic techniques, including x-ray, endoscopy, imaging, ultrasound, exploratory surgery (e.g. laparotomy), and autopsy, without a tissue diagnosis
4	Specific tumour markers: Including biochemical and/or immunological markers that are specific for a tumour site
5	Cytology: Examination of cells from a primary or secondary site, including fluids aspirated by endoscopy or needle; also includes the microscopic examination of peripheral blood and bone marrow aspirates
6	Histology of metastasis: Histological examination of tissue from a metastasis, including autopsy specimens
7	Histology of a primary tumour: Histological examination of tissue from primary tumour, however obtained, including all cutting techniques and bone marrow biopsies; also includes autopsy specimens of primary tumour
8	Histology: either unknown whether of primary or metastatic site, or not otherwise specified

Supplementary values:

9	Unknown.

Collection and usage attributes

Guide for use:

CODES 1 - 4

Non-microscopic.

CODES 5 - 8

Microscopic.

CODE 9

Other.

Comments:

In a hospital setting this metadata item should be collected on the most valid basis of diagnosis at this admission. If more than one diagnosis technique is used during an admission, select the higher code from 1 to 8.

Data element attributes

Collection and usage attributes

Guide for use:

The most valid basis of diagnosis may be the initial histological examination of the primary site, or it may be the post-mortem examination (sometimes corrected even at this point when histological results become available). In a cancer registry setting, this metadata item should be revised if later information allows its upgrading.

When considering the most valid basis of diagnosis, the minimum requirement of a cancer registry is differentiation between neoplasms that are verified microscopically and those that are not. To exclude the latter group means losing valuable information; the making of a morphological (histological) diagnosis is dependent upon a variety of factors, such as age, accessibility of the tumour, availability of medical services, and, last but not least, upon the beliefs of the patient.

A biopsy of the primary tumour should be distinguished from a biopsy of a metastasis, e.g., at laparotomy; a biopsy of cancer of the head of the pancreas versus a biopsy of a metastasis in the mesentery. However, when insufficient information is available, Code 8 should be used for any histological diagnosis. Cytological and histological diagnoses should be distinguished.

Morphological confirmation of the clinical diagnosis of malignancy depends on the successful removal of a piece of tissue that is cancerous. Especially when using endoscopic procedures (bronchoscopy, gastroscopy, laparoscopy, etc.), the clinician may miss the tumour with the biopsy forceps. These cases must be registered on the basis of endoscopic diagnosis and not excluded through lack of a morphological diagnosis.

Care must be taken in the interpretation and subsequent coding of autopsy findings, which may vary as follows:

a) the post-mortem report includes the post-mortem histological diagnosis (in which case, one of the Histology codes should be recorded instead);

b) the autopsy is macroscopic only, histological investigations

having been carried out only during life (in which case, one of the Histology codes should be recorded instead);

c) the autopsy findings are not supported by any histological diagnosis.

Source and reference attributes

Origin: International Agency for Research on Cancer

International Association of Cancer Registries

Relational attributes

Related metadata references: Supersedes Most valid basis of diagnosis of cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (47.0 KB)

Implementation in Data Set Specifications: Breast cancer (Cancer registries) DSS Health, Standard 06/03/2009

Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Superseded 06/03/2009

Cancer (clinical) DSS Health, Superseded 22/12/2009

Cancer (clinical) DSS Health, Standard 22/12/2009

Mother's original family name

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—mother's original family name, text [X(40)]
METeOR identifier:	270262
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005
Definition:	The original family name of the person's mother as reported by the person, as represented by text.
Data Element Concept:	Person—mother's original family name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(40)]
Maximum character length:	40

Data element attributes

Collection and usage attributes

Guide for use:	Mixed case should be used (rather than upper case only).
Collection methods:	See relevant paragraphs in the collection methods section of the metadata item Person (name)—family name, text X[X(39)].

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	National Health Data Committee National Community Services Data Committee Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Relational attributes

Related metadata references:	Supersedes Mother's original family name, version 2, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005.pdf (14.1 KB)
Implementation in Data Set Specifications:	Health care client identification Health, Superseded 04/05/2005 Health care client identification DSS Health, Superseded 03/12/2008 Health care client identification DSS Health, Standard 03/12/2008

Multi-disciplinary team status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient service event—multi-disciplinary team status, code N
METeOR identifier:	270104
Registration status:	Health, Standard 01/03/2005
Definition:	Whether a non-admitted patient service event involved a multi-disciplinary team, as represented by a code.
Data Element Concept:	Non-admitted patient service event—multi-disciplinary team status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Non-admitted multi-disciplinary team patient service event
2	Other non-admitted patient service event

Data element attributes

Relational attributes

Related metadata references: Supersedes Multi-disciplinary team status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.7 KB)

Myocardial infarction (history)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—myocardial infarction (history), code N
METeOR identifier:	270285
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the individual has had a myocardial infarction, as represented by a code.
Data Element Concept:	Person—myocardial infarction

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Myocardial infarction - occurred in the last 12 months
2	Myocardial infarction - occurred prior to the last 12 months
3	Myocardial infarction - occurred both in and prior to the last 12 months
4	No history of myocardial infarction

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Collection methods:

Ask the individual if he/she has had a myocardial infarction. If so determine whether it was within or prior to the last 12 months (or both).Record if evidenced by ECG changes or plasma enzyme changes.

Alternatively obtain this information from appropriate documentation.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.
Reference documents:	Long-term Results From the Diabetes and Insulin-Glucose Infusion in Acute Myocardial Infarction (DIGAMI) Study Circulation. 1999;99: 2626-2632.

Relational attributes

Related metadata references:	Supersedes Myocardial infarction - history, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.7 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008
	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005
	Diabetes (clinical) DSS Health, Superseded 21/09/2005
	Diabetes (clinical) DSS Health, Standard 21/09/2005

Name context flag

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (name)—name conditional use flag, code N
Synonymous names:	Name conditional use flag
METeOR identifier:	287101
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005
Definition:	An indicator of specific conditions that may be applied to an individual's name, as represented by a code.
Data Element Concept:	Person (name)—name conditional use flag

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Unreliable information
2	Name not for continued use
3	Special privacy/security requirement

Data element attributes

Collection and usage attributes

Guide for use:

A single Person name may have multiple Name conditional use flags associated with it. Record as many as applicable.

CODE 1 Unreliable information: should be used where it is known that the name recorded is a fictitious or partial name. These names should not be used for matching client data.

CODE 2 Name not for continued use, indicates that this name should NOT be used when referring to this person. The name is retained for identification purposes only. For Aboriginal and Torres Strait Islanders, certain tribal names may become 'not for continued use' due to the death of a relative.

CODE 3 Special privacy/security requirements– may apply to names for which episodes are attached that should only be accessible to specified authorised persons. There must be a specific need to implement this additional security level. Local policy should provide guidance to the use of this code.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	National Health Data Committee
	National Community Services Data Committee
	Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia
Reference documents:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references:	Supersedes Person (name)—name context flag, code N Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005
Implementation in Data Set Specifications:	Health care client identification DSS Health, Superseded 03/12/2008
	Health care client identification DSS Health, Standard 03/12/2008
	Health care provider identification DSS Health, Superseded 04/07/2007
	Health care provider identification DSS Health, Superseded 03/12/2008
	Health care provider identification DSS Health, Standard 03/12/2008

Name suffix

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (name)—name suffix, text [A(12)]
METeOR identifier:	287164
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005
Definition:	Additional term following a person's name used to identify a person when addressing them by name, whether by mail, by phone, or in person, as represented by text.
Data Element Concept:	Person (name)—name suffix

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[A(12)]
Maximum character length:	12

Collection and usage attributes

Guide for use:	Valid abbreviations from the Australian Standard AS4590-1999 Interchange of client information.

Source and reference attributes

Origin:	Standards Australia 1999. Australian Standard AS4590-1999 Interchange of Client Information. Sydney: Standards Australia Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Data element attributes

Collection and usage attributes

Guide for use:	Mixed case should be used (rather than upper case only). Examples of name suffixes are 'Jr' for Junior and 'MP' for Member of Parliament.
Collection methods:	A person's name may have multiple Name suffixes. For the purpose of positive identification of a person, each Name suffix must have an associated Name suffix sequence number recorded.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	National Health Data Committee National Community Services Data Committee

Reference documents: AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references: Supersedes Person (name)—name suffix, text [A(12)] Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005

Implementation in Data Set Specifications: Health care client identification DSS Health, Superseded 03/12/2008

Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Superseded 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Name suffix sequence number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (name)—name suffix sequence number, code N
METeOR identifier:	288226
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The numeric order of any additional terms used at the conclusion of a name, as represented by a code.
Data Element Concept:	Person (name)—name suffix sequence number

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	First name suffix
2	Second name suffix
3	Third name suffix
4	Fourth name suffix
5	Fifth name suffix
6	Sixth name suffix
7	Seventh name suffix
8	Eighth name suffix
9	Ninth and subsequent name suffix

Data element attributes

Collection and usage attributes

Collection methods:

Multiple Name suffixes may be recorded. A Name suffix sequence number must be recorded for each Name suffix.

Example: For the name 'John Markham Jr MP', 'Jr' would have a name suffix sequence number of 1 and 'MP' would have a name suffix sequence number of 2.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Implementation in Data Set Specifications:	Health care client identification DSS Health, Superseded 03/12/2008
	Health care client identification DSS Health, Standard 03/12/2008
	Health care provider identification DSS Health, Superseded 04/07/2007
	Health care provider identification DSS Health, Superseded 03/12/2008
	Health care provider identification DSS Health, Standard 03/12/2008

Name title

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (name)—name title, text [A(12)]
METeOR identifier:	287166
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005
Definition:	An honorific form of address, commencing a name, used when addressing a person by name, whether by mail, by phone, or in person, as represented by text.
Data Element Concept:	Person (name)—name title

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	A(12)
Maximum character length:	12

Collection and usage attributes

Guide for use:	Valid abbreviations from the Australian Standard AS4590-1999 Interchange of client information.

Source and reference attributes

Origin:	Standards Australia 1999. Australian Standard AS4590-1999 Interchange of Client Information. Sydney: Standards Australia Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Data element attributes

Collection and usage attributes

Guide for use:	Mixed case should be used (rather than upper case only). The Name title for Master should only be used for persons less than 15 years of age. Name titles for Doctor and Professor should only be applicable to persons of greater than 20 years of age. More than one Name title may be recorded e.g. Prof Sir John Markham.

Source and reference attributes

Submitting organisation:	Standards Australia

Origin:	National Health Data Committee National Community Services Data Committee
Reference documents:	Standards Australia 1999. Australian Standard AS4590-1999 Interchange of Client Information. Sydney: Standards Australia Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references:	Supersedes Person (name)—name title, text [A(12)] Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005
Implementation in Data Set Specifications:	Health care client identification DSS Health, Superseded 03/12/2008 Health care client identification DSS Health, Standard 03/12/2008 Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Superseded 03/12/2008 Health care provider identification DSS Health, Standard 03/12/2008

Name title sequence number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (name)—name title sequence number, code N
METeOR identifier:	288263
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The numeric order of an honorific form of address commencing a person's name, as represented by a code.
Data Element Concept:	Person (name)—name title sequence number

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	First name title
2	Second name title
3	Third name title
4	Fourth name title
5	Fifth name title
6	Sixth name title
7	Seventh name title
8	Eighth name title
9	Ninth and subsequent name title

Data element attributes

Collection and usage attributes

Collection methods:

Multiple Name titles may be recorded. For the purpose of positive identification of a person, each Name title must have a Name title sequence number recorded.

Example: Professor Sir John Markham

In the example above 'Professor' would have a name title sequence number of 1 and 'Sir' would have a name title sequence number of 2.

Source and reference attributes

Submitting organisation:	Standards Australia

Origin: AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Implementation in Data Set Specifications:

Health care client identification DSS Health, Superseded 03/12/2008

Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Superseded 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Name type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (name)—name type, code N
METeOR identifier:	287203
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	A classification that enables differentiation between recorded names for a person, as represented by a code.
Data Element Concept:	Person (name)—name type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Preferred name
2	Medicare name
3	Newborn name
4	Alias name

Data element attributes

Collection and usage attributes

Guide for use:

A person may have more than one name that they use. At least one name must be recorded for each person. Each name recorded must have one or more appropriate Person name type associated with it. Record all that are required.

One name is sufficient; however, where the person offers more than one name, clarification should be obtained from the person to ensure accurate identification of the person and recording of the various names. The currently used name, as well as names by which the person has previously been known, should be recorded if these are known.

Field value definitions for Person name type codes are:

CODE 1 Preferred name is the name by which the person chooses to be identified.

There should only be one preferred name recorded for a person. Where the person changes their preferred name, record the previously recorded preferred name as an Alias name. Preferred name is the default name type (i.e. if only one name is recorded it

should be the person's preferred name). There must be a preferred name recorded except for unnamed newborns where the newborn name is the only name recorded.

Also, if the person is a health care client, record his/her Medicare card name if different to the preferred name, and any known alias names.

CODE 2 Medicare name for a health care client, this is the person's name as it appears on their Medicare card. The name stated on the Medicare card is required for all electronic Medicare claim lodgement. If the preferred name of the person is different to the name on the Medicare card, the Medicare card name should also be recorded. For an individual health care provider, this is the person's name registered by Medicare (Health Insurance Commission).

CODE 3 Newborn name: type is reserved for the identification of unnamed newborn babies.

CODE 4 Alias name is any other name that a person is also known by, or has been known by in the past; that is, all alias names. This includes misspelt names or name variations that are to be retained as they have been used to identify this person. More than one alias name may be recorded for a person.

Source and reference attributes

Submitting organisation: Standards Australia

Origin: National Health Data Committee

National Community Services Data Committee

AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia

Reference documents: AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia
In AS5017 and AS4846 alternative alphabetic codes are presented. Refer to the current standard for more details.

Relational attributes

Related metadata references: Supersedes Person (name)—name type, code A Health, Superseded 04/05/2005

Implementation in Data Set Specifications: Health care client identification DSS Health, Superseded 03/12/2008

Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Superseded 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Name type (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (name)—name type, code N
METeOR identifier:	288937
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	A classification that enables differentiation between recorded names for an establishment, agency or organisation, as represented by a code.
Data Element Concept:	Service provider organisation (name)—name type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Organisation unit/section/division
2	Service location name
3	Business name
4	Locally used name
5	Abbreviated name
6	Enterprise name
8	Other

Supplementary values:

9	Unknown

Collection and usage attributes

Guide for use:

CODE 1 Organisation unit/section/division

This code is used where a business unit, section or division within an organisation may have its own separate identity.

CODE 2 Service location name

This code is used where the service location name is an important part of the organisation name and is used for identification purposes, e.g. Mobile Immunisation Unit at Bankstown.

CODE 3 Business name

Business name used only for trading purposes.

CODE 4 Locally used name

This code is used where a local name is used, e.g. where a medical practice is known by a name that is different to the company registration name or business name.

CODE 5 Abbreviated name

A short name or an abbreviated name by which the organisation is known, e.g. HIC.

CODE 6 Enterprise name

Generally, the complete organisation name should be used to avoid any ambiguity in identification. This should usually be the same as company registration name.

CODE 8 Other

This code is used when the organisation name does not fit into any one of the categories listed above.

CODE 9 Unknown

This code is used when the organisation name type is unknown.

Data element attributes

Collection and usage attributes

Guide for use:

At least one organisation name must be recorded for each organisation and each name must have an appropriate Organisation name type.

Relational attributes

Implementation in Data Set Specifications:

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Superseded 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Narrative description of injury event

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—external cause, text [X(100)]
METeOR identifier:	268946
Registration status:	Health, Standard 01/03/2005
Definition:	A textual description of the environmental event, circumstance or condition as the cause of injury, poisoning and other adverse effect.
Data Element Concept:	Injury event—external cause

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(100)]
Maximum character length:	100

Data element attributes

Collection and usage attributes

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 be indicated.
Comments:	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. 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.

Source and reference attributes

Submitting organisation:	National Injury Surveillance Unit, Flinders University, Adelaide

Relational attributes

Related metadata references:	Supersedes Narrative description of injury event, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB)
Implementation in Data Set	Injury surveillance DSS Health, Superseded 05/02/2008

Specifications:

Injury surveillance DSS Health, Superseded 14/12/2009

Injury surveillance DSS Health, Standard 14/12/2009

Injury surveillance NMDS Health, Superseded 03/05/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Injury surveillance NMDS Health, Superseded 07/12/2005

National standards for mental health services review status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service unit—implementation of National standards for mental health services status, code N
METeOR identifier:	287800
Registration status:	Health, Standard 08/12/2004
Definition:	The extent of progress made by a specialised mental health service unit in implementing the National Standards for Mental Health Services by or at 30 June, as represented by a code.
Data Element Concept:	Specialised mental health service unit—implementation of National standards for mental health services status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	The service unit had been reviewed by an external accreditation agency and was judged to have met the National standards
2	The service unit had been reviewed by an external accreditation agency and was judged to have met some but not all of the National standards
3	The service unit was in the process of being reviewed by an external accreditation agency but the outcomes were not known
4	The service unit was booked for review by an external accreditation agency and was engaged in self-assessment preparation prior to the formal external review
5	The service unit was engaged in self-assessment in relation to the National Standards but did not have a contractual arrangement with an external accreditation agency for review
6	The service unit had not commenced the preparations for review by an external accreditation agency but this was intended to be undertaken in the future
7	It had not been resolved whether the service unit would undertake review by an external accreditation agency under the National standards

8	The National standards are not applicable to this service unit

Collection and usage attributes

Guide for use:

Code 8 The National standards are not applicable to this service unit

This code should only be used for:

- non-government organisation mental health services and private hospitals (that receive some government funding to provide specialised mental health services) where implementation of National standards for mental health services has not been agreed with the relevant state or territory; or
- those aged care residential services (e.g. psychogeriatric nursing homes) in receipt of funding under the *Aged Care Act* and subject to Commonwealth residential aged care reporting and service standards requirements.

Data element attributes

Collection and usage attributes

Collection methods:

Report the review/accreditation status at 30 June for each service unit for the National standards for mental health services using the standard set of codes shown in the value domain.

For organisations that include more than one service unit the codes relating to each service should be completed. Reporting of progress at the individual service unit level recognises that parts rather than whole organisations may be implementing the standards.

NOTE: for admitted patient setting only, these data need to be disaggregated by specialised mental health service program type and specialised mental health service target population.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Nature of main injury (non-admitted patient)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—nature of main injury, non-admitted patient code NN{.N}
METeOR identifier:	268947
Registration status:	Health, Standard 01/03/2005
Definition:	The nature of the injury chiefly responsible for the attendance of the non-admitted patient at the health care facility, at represented by a code.
Data Element Concept:	Injury event—nature of main injury

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN{.N}
Maximum character length:	4

Permissible values:

Value	Meaning
01	Superficial (excludes eye injury code 13)
02	Open wound (excludes eye injury code 13)
03	Fracture (excludes dental injury code 21)
04	Dislocation (includes ruptured disc, cartilage, ligament)
05	Sprain or strain
06	Injury to nerve (includes spinal cord; excludes intracranial injury code 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 injury code 13)
13	Eye injury (includes burns, excludes foreign body in external eye code 14.1)
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 code 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 immersion code 22)
24	Electrical injury
25	Poisoning, toxic effect (excludes effect of venom, or any insect bite code 26)
26	Effect of venom, or any insect bite
27	Other specified nature of injury
28	Injury of unspecified nature
29	Multiple injuries of more than one 'nature'
30	No injury detected

Data element attributes

Collection and usage attributes

Guide for use:

If the full ICD-10-AM code is used to code the injury, this metadata item is not required (see metadata items principal diagnosis and additional diagnosis) When coding to the full ICD-10-AM code is not possible, use this metadata item with the items external cause of injury-non admitted patient, external cause of injury-human intent and bodily location of main injury.

Select the code 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 the metadata item 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. Bodily location of main injury, category 22 may be used as a filler to indicate that specific body region is not required.

Comments:

Injury diagnosis is necessary for purposes including epidemiological research, casemix studies and planning. This metadata item together with the metadata item bodily location of the main injury indicates the diagnosis.

This metadata 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 metadata item principal diagnosis) is not available in most settings where basic injury surveillance is undertaken. This item, in combination with the metadata item 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.

Source and reference attributes

Submitting organisation:

National Injury Surveillance Unit, Flinders University, Adelaide

National Data Standards for Injury Surveillance Advisory Group

Relational attributes

Related metadata references:

See also Person—bodily location of main injury, code NN Health, Standard 01/03/2005

Supersedes Nature of main injury - non-admitted patient, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.3 KB)

Implementation in Data Set Specifications:

Injury surveillance DSS Health, Superseded 05/02/2008

Injury surveillance DSS Health, Superseded 14/12/2009

Injury surveillance DSS Health, Standard 14/12/2009

Injury surveillance NMDS Health, Superseded 03/05/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Injury surveillance NMDS Health, Superseded 07/12/2005

Neo-adjuvant therapy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—neoadjuvant therapy indicator, code N
METeOR identifier:	370014
Registration status:	Health, Standard 06/03/2009
Definition:	Whether a person with a solid tumour has received neoadjuvant therapy, as represented by a code.
Data Element Concept:	Person with cancer—neoadjuvant therapy indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

To be reported when therapy is received after a diagnosis of cancer and prior to primary surgical treatment.

This data item is used to flag cases in which tumour descriptors, for example solid tumour size, may be inaccurate due to shrinkage from neoadjuvant therapy.

Yes - indicates that the client has received neo-adjuvant therapy after a diagnosis of cancer and prior to primary surgical treatment

No - indicates that the client did not receive neo-adjuvant therapy after a diagnosis of cancer and prior to primary surgical treatment

For invasive breast cancer:

Information is obtained from

- Clinical notes on pathology report mentions that patient underwent chemotherapy prior to surgery
- Microscopy section of pathology report describes tumour changes as a result of neoadjuvant therapy (coder may be alerted to look for this detail by a long interval between biopsy and wider excision)

- Hospital notification indicates that admission if for chemotherapy only (and admission date is before that for surgery)

Comments:

Preoperative chemotherapy and/or radiotherapy may be received after a diagnosis of cancer but before surgical treatment.

The effects of chemotherapy and/or radiotherapy prior to surgery will shrink the tumour and so the size of the tumour found from the subsequent surgical excision will be smaller than the original size of the tumour at the time of diagnosis. This impacts on the TNM-T and staging classification, and is important to take into account for analysis and research.

Source and reference attributes

Origin:

National Breast and Ovarian Cancer Centre (NBOCC)

Australasian Association of Cancer Registries (AACR)

Australian Institute of Health and Welfare (AIHW)

Reference documents:

Johnson CH, Adamo M (eds.), SEER Program Coding and Staging Manual 2007. National Cancer Institute, NIH Publication number 07-5581, Bethesda, MD 2007.

Relational attributes

Implementation in Data Set Specifications:

Breast cancer (Cancer registries) DSS Health, Standard 06/03/2009

Neonatal morbidity

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Admitted patient (neonate)—neonatal morbidity, code (ICD-10-AM 7th edn) ANN{.N[N]}
METeOR identifier:	391332
Registration status:	Health, Standard 22/12/2009
Definition:	Conditions or diseases of the baby, as represented by an ICD-10-AM code.
Data Element Concept:	Admitted patient (neonate)—neonatal morbidity

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Collection and usage attributes

Guide for use:	Conditions should be coded within chapter of Volume 1, ICD-10-AM.

Data element attributes

Collection and usage attributes

Guide for use:	There is no arbitrary limit on the number of conditions specified.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Admitted patient (neonate)—neonatal morbidity, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009

Net capital expenditure (accrual accounting)—buildings and building services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (buildings and building services) (financial year), total Australian currency N[N(8)]
METeOR identifier:	269969
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure, measured in Australian dollars, on buildings and building services (including plant).
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (buildings and building services)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.2 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Net capital expenditure (accrual accounting)—constructions

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (constructions) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270531
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure, measured in Australian dollars, on constructions (other than buildings).
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (constructions)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.2 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health,

Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Net capital expenditure (accrual accounting)—equipment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (equipment) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270534
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure, measured in Australian dollars, on equipment.
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (equipment)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.2 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Net capital expenditure (accrual accounting)—information technology

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (information technology) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270529
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure, measured in Australian dollars, on information technology.
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (information technology)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.2 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Net capital expenditure (accrual accounting)—intangible assets

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (intangible assets) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270535
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure, measured in Australian dollars, on intangible assets.
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (intangible assets)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.2 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Net capital expenditure (accrual accounting)—land

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (land) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270536
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure, measured in Australian dollars, on land.
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (land)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.2 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Net capital expenditure (accrual accounting)—major medical equipment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (major medical equipment) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270530
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure, measured in Australian dollars, on major medical equipment.
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (major medical equipment)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.2 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Net capital expenditure (accrual accounting)—other equipment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (other equipment) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270533
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure, measured in Australian dollars, on other equipment, such as furniture, art objects, professional instruments and containers.
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (other equipment)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.2 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Net capital expenditure (accrual accounting)—transport

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (transport) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270532
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure measured in Australian dollars on transport.
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (transport)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.2 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

New/repeat status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient service event—new/repeat status, code N
METeOR identifier:	270348
Registration status:	Health, Standard 01/03/2005
Definition:	Whether a non-admitted patient service event is for a new problem not previously addressed at the same clinical service or for a repeat service event, as represented by a code.
Data Element Concept:	Non-admitted patient service event—new/repeat service event status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	New non-admitted patient service event
2	Repeat non-admitted patient service event

Collection and usage attributes

Guide for use:

CODE 1 New non-admitted patient service event:

New service events occur as each type of clinical service makes their full assessment consultation with the patient.

CODE 2 Repeat non-admitted patient service event:

Repeat visits include completion of an ambulatory procedure e.g. removal of sutures and removal of plaster casts.

Data element attributes

Relational attributes

Related metadata references: Supersedes New/repeat status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB)

Non-Australian state/province (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—non-Australian state/province, text [X(40)]
Synonymous names:	International state/province
METeOR identifier:	288648
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The designation applied to an internal, political or geographic division of a country other than Australia that is officially recognised by that country that is associated with the address of a person, as represented by text.
Data Element Concept:	Person (address)—non-Australian state/province

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(40)]
Maximum character length:	40

Data element attributes

Collection and usage attributes

Guide for use:	The name of the state or territory or province should be recorded using the standard ASCII character set and should be done so in accordance with the official conventions of the country, for example, Hunan rather than Chinese characters.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare Standard Australia
Origin:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia
Reference documents:	AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

Implementation in Data Set Specifications:	Health care client identification DSS Health, Superseded 03/12/2008 Health care client identification DSS Health, Standard 03/12/2008 Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Superseded 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Non-Australian state/province (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—non-Australian state/province, text [X(40)]
METeOR identifier:	288636
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The designation applied to an internal, political or geographic division of a country other than Australia that is officially recognised by that country that is associated with the address of an establishment, as represented by text.
Data Element Concept:	Service provider organisation (address)—non-Australian state/province

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(40)]
Maximum character length:	40

Data element attributes

Collection and usage attributes

Guide for use:	The name of the state or territory or province should be recorded using the standard ASCII character set and should be done so in accordance with the official conventions of the country.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007
	Health care provider identification DSS Health, Superseded 03/12/2008
	Health care provider identification DSS Health, Standard 03/12/2008

Non-instrumented bleeding location

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with acute coronary syndrome—bleeding location, non-instrumented code N(N)
Synonymous names:	Non-instrumented bleeding site
METeOR identifier:	372012
Registration status:	Health, Standard 01/10/2008
Definition:	The location of the person's bleeding episode, arising from a non-instrumented site, as represented by a code.
Data Element Concept:	Person with acute coronary syndrome—bleeding location

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	Gastrointestinal site
2	Genitourinary site
3	Intracranial site
4	Pulmonary site
5	Pericardial site
6	Other site(s)
7	Unidentified site

Supplementary values:

99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

NOTE: Excludes bleeding arising from instrumented sites.

CODE 1 Gastrointestinal site

Use this code when the person's spontaneous bleeding is originating from the gastrointestinal area.

CODE 2 Genitourinary site

Use this code when the person's spontaneous bleeding is originating from the genitourinary area.

CODE 3 Intracranial site

Use this code when the person's spontaneous bleeding is originating from an intracranial site.

CODE 4 Pulmonary site

Use this code when the person's spontaneous bleeding is originating from a pulmonary site.

CODE 5 Pericardial site

Use this code when the person's spontaneous bleeding is originating from the pericardium.

CODE 6 Other site(s)

Use this code when the person's spontaneous bleeding is originating from a site not listed in codes 1-5.

CODE 7 Unidentified site

Use this code when the person has a fall in haemoglobin without an identifiable spontaneous site of bleeding.

CODE 99 Not stated/inadequately described

Not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use: Record the location of all bleeding events that occur. More than one code can be applied.

Relational attributes

Related metadata references: See also Person with acute coronary syndrome—bleeding location, instrumented code N(N) Health, Standard 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Number of caesarean sections

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—number of caesarean sections, total count N[N]
METeOR identifier:	297820
Registration status:	Health, Standard 29/11/2006
Definition:	The total number of previous caesarean sections performed on the woman.
Data Element Concept:	Female—number of caesarean sections

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]
Maximum character length:	2

Supplementary values:

Value	Meaning
99	Not stated/Inadequately described

Unit of measure: Caesarean sections

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Data element attributes

Collection and usage attributes

Guide for use: In the case of multiple births, count the number of operations the mother has had, rather than the number of babies born.

Exclude the current birth if by caesarean section.

Record as 0 if no previous caesarean sections.

Comments: Previous caesarean sections are associated with a higher risk of obstetric complications, and when used with other indicators provides important information on the quality of obstetric care.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Number of contacts—psychiatric outpatient clinic/day program

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—number of psychiatric outpatient clinic/day program attendances (financial year), total days N[NN]
METeOR identifier:	270121
Registration status:	Health, Standard 01/03/2005
Definition:	Number of days that a patient attended a psychiatric outpatient clinic or a day program during the relevant financial year.
Data Element Concept:	Patient—number of psychiatric outpatient clinic/day program attendances

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Day

Data element attributes

Collection and usage attributes

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.)
Comments:	This metadata item gives a measure of the level of service provided. In December 1998, the National Health Information Management Group decided that the new version of this metadata item (named Person—number of service contact dates, total N[NN]) would be implemented from 1 July 2000 in the Community Mental Health National Minimum Data Set (NMDS). Until then agencies involved in the Community mental health NMDS may report either Patient—number of psychiatric outpatient clinic/day program attendances (financial year), total days N[NN] or Person—number of service contact dates, total N[NN] with the expectation that agencies will make their best efforts to report against the new version of this metadata item (Person—number of service contact dates, total N[NN]) from 1 July 1999.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Number of contacts (psychiatric outpatient clinic/day program), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB)

Number of coronary artery lesions attempted

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—count of coronary artery lesions attempted, total number N[N]
METeOR identifier:	344404
Registration status:	Health, Standard 01/10/2008
Definition:	A count of number of a person's coronary artery lesions into which an attempt was made to pass a percutaneous coronary intervention (PCI) guidewire.
Data Element Concept:	Person—count of coronary artery lesions attempted

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

Record the total number of lesions into which an attempt was made to pass a PCI guidewire during a single given PCI procedure, whether they were successful or not.

The number of lesions attempted should be reported for each PCI performed.

The value '99' is not for use in primary data collections.

Collection methods:

The number of lesions attempted should be recorded from the angioplasty report.

Relational attributes

Implementation in Data Set Specifications:

Coronary artery cluster Health, Standard 01/10/2008

Conditional obligation:
Record when a percutaneous coronary intervention is performed.

Number of coronary artery lesions successfully dilated

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—count of coronary artery lesions successfully dilated, total number N[N]
METeOR identifier:	344411
Registration status:	Health, Standard 01/10/2008
Definition:	The number of a person's coronary artery lesions successfully dilated.
Data Element Concept:	Person—count of coronary artery lesions successfully dilated

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

The number of lesions successfully dilated should be recorded for each percutaneous coronary intervention (PCI) performed.

Successful dilation is where:

- residual stenosis is less than 10% following coronary stenting; OR
- residual stenosis is less than 50% after balloon angioplasty alone.

The value '99' is not for use in primary data collections.

Collection methods:

The number of lesions successfully dilated should be recorded from the angioplasty report.

Relational attributes

Implementation in Data Set Specifications:

Coronary artery cluster Health, Standard 01/10/2008

Conditional obligation:
Record when a percutaneous coronary intervention is performed.

Number of coronary artery stents

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—count of coronary artery stents, total number N[N]
METeOR identifier:	344417
Registration status:	Health, Standard 01/10/2008
Definition:	The number of stents placed during a person's angioplasty procedure.
Data Element Concept:	Person—count of coronary artery stents

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	N[N]	
Supplementary values:	Value	Meaning
	99	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	The value '99' is not for use in primary data collections.
Collection methods:	Record the total number of coronary stents placed during the entire angioplasty procedure, regardless of the number of individual lesions.

Relational attributes

Implementation in Data Set Specifications:	Coronary artery cluster Health, Standard 01/10/2008 *Conditional obligation:* Record when a percutaneous coronary intervention with stent implantation (bare metal stent or drug eluting stent) is performed.

Number of days in special/neonatal intensive care

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—length of stay (special/neonatal intensive care), total days N[NN]
METeOR identifier:	270057
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of days spent by a neonate in a special care or neonatal intensive care nursery (in the hospital of birth).
Data Element Concept:	Episode of admitted patient care—length of stay (special/neonatal intensive care)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Day

Data element attributes

Collection and usage attributes

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 (SCN).
Comments:	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. 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 NICN also provide consultative services to other hospitals.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Number of days in special / neonatal intensive care, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.9 KB)

Number of days of hospital-in-the-home care

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—number of days of hospital-in-the-home care, total {N[NN]}
METeOR identifier:	270305
Registration status:	Health, Standard 01/03/2005
Definition:	The number of **hospital-in-the-home** days occurring within an episode of care for an admitted patient.
Data Element Concept:	Episode of admitted patient care—number of days of hospital-in-the-home care

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	{N[NN]}
Maximum character length:	3
Unit of measure:	Day

Data element attributes

Collection and usage attributes

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.

Comments:

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.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Number of days of hospital-in-the-home care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.0 KB)

Implementation in Data Set Specifications:

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Admitted patient palliative care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient palliative care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient palliative care NMDS 2007-08 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient palliative care NMDS 2008-09 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient palliative care NMDS 2009-10 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient palliative care NMDS 2010-11 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Number of episodes of angina in last 24 hours

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—angina episodes count (24 hours preceding hospital presentation), total number NN[N]
METeOR identifier:	338293
Registration status:	Health, Standard 01/10/2008
Definition:	The number of angina episodes experienced by a person in the 24 hours preceding presentation to the hospital, including the current episode.
Data Element Concept:	Person—count of angina episodes

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NN[N]
Maximum character length:	3

Supplementary values:

Value	Meaning
999	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

Is the total number of distinct episodes of anginal pain that occurred in the 24 hours preceding presentation to the hospital, including the current episode for which the person presented to hospital.

An episode of angina may include chest pain (which may spread to either or both shoulders, the back, neck, jaws or down the arm) or overwhelming shortness of breath.

Collection methods:

Ask the individual how many distinct episodes of anginal pain he/she experienced in the 24 hours preceding presentation to hospital, including the current episode. Alternatively, if available, obtain this information from appropriate documentation.

Relational attributes

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Number of episodes of residential care

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of residential care—number of episodes of residential care, total N[NNN]
METeOR identifier:	287957
Registration status:	Health, Standard 08/12/2004
Definition:	The total number of episodes of completed residential care occurring during the reference period (between 1 July and 30 June each year). This includes both formal and statistical episodes of residential care.
Data Element Concept:	Episode of residential care—number of episodes of residential care

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Data element attributes

Collection and usage attributes

Guide for use:	The sum of the number of episodes of residential care where the Episode of residential care end date has a value: • Equal to or greater than the beginning of the reference period (01 July each year); and • Less than or equal to the end of the reference period (30 June each year at midnight).
Collection methods:	To be reported for all specialised residential mental health care services, including non-government residential mental health care services and

Relational attributes

Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Mental health establishments NMDS 2006-2007 Health,

Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Number of group sessions

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group sessions, total N[NNNNN]
Synonymous names:	Group occasions of service
METeOR identifier:	336900
Registration status:	Health, Standard 04/07/2007
Definition:	The total number of groups of patients receiving services. Each group is to be counted once, irrespective of the size of the group of patients or the number of staff providing services.
Data Element Concept:	Establishment—number of group sessions

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:

A group is defined as two or more patients receiving the same services at the same time from the same hospital staff at the same clinics.

The following guides for use apply:

- a group session is counted only for two or more patients attending in the capacity of patients in their own right, even if other non-patient persons are present for the service.
- Spouses, parents or carers attending the session are counted for the group session only if they are also participating in the service as a patient.
- A group session is counted for staff attending clinics only if they are attending as a patient in their own right. Staff training and education is excluded.
- A group session may be delivered by more than one provider. A group session is counted for two or more patients receiving the same services, even if more than one provider delivers that service simultaneously.
- Patients attending for treatment at a dialysis or a chemotherapy clinic are receiving individual services. Patients attending education sessions at chemotherapy or

dialysis clinics are counted as group sessions, if two or more people are receiving the same services at the same time.

Collection methods: Where a patient receives multidisciplinary care within one booked clinic appointment as part of a group, one group session shall be recorded, regardless of the number of providers involved. For example, if a group session is jointly delivered by a physiotherapist and an occupational therapist, one group session is counted for the patients attending that session.

Source and reference attributes

Submitting organisation: Non-admitted patient NMDS Development Working Party, 2006

Relational attributes

Related metadata references: Supersedes Establishment—number of group sessions, total N[NNNNN] Health, Superseded 04/07/2007

Implementation in Data Set Specifications: Outpatient care NMDS Health, Standard 04/07/2007

Implementation start date: 01/07/2007

Number of leave periods

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—number of leave periods, total N[N]
METeOR identifier:	270058
Registration status:	Health, Standard 01/03/2005
Definition:	Number of leave periods in a hospital stay (excluding one-day leave periods for admitted patients).
Data Element Concept:	Episode of admitted patient care—number of leave periods

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]
Maximum character length:	2
Unit of measure:	Period

Data element attributes

Collection and usage attributes

Guide for use:	If the period of leave is greater than seven days or the patient fails to return from leave, the patient is discharged.
Comments:	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. 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.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Number of leave periods, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.5 KB) Is used in the formation of Episode of admitted patient care—length of stay (excluding leave days), total N[NN] Health, Standard 01/03/2005

Number of occasions of service

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of occasions of service, total N[NNNNNN]
Synonymous names:	Individual occasions of service
METeOR identifier:	336947
Registration status:	Health, Standard 04/07/2007
Definition:	The total number of occasions of examination, consultation, treatment or other service provided to a patient.
Data Element Concept:	Establishment—number of occasions of service

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:

The following guides for use apply:

- an occasion of service is counted for each person attending in the capacity of a patient in their own right, even if other non-patient persons are present for the service.
- spouses, parents or carers attending the session are only counted if they are also participating in the service as a patient.
- in the instance of a dependent child presenting to a clinic, the session is counted as a single Occasion of Service provided to the individual child for whom an event history is being recorded. Where parents/carers also attend in the capacity of patients themselves within a booked appointment, and receive the same services at the same time, the child and parent/carer can be counted as a group. In this instance a Group Session count would be recorded.
- An occasion of service is counted for staff attending clinics of public hospitals only if they are attending as patients in their own right. Staff education and training is excluded.
- Patients attending for treatment at a dialysis or a chemotherapy clinic are receiving individual services. Patients attending education sessions at chemotherapy or

dialysis clinics are counted as group sessions, if two or more people receiving the same services at the same time.

Collection methods:

- Where a patient receives the occasion of service is counted at the clinic of the public hospital where the patient is booked.
- Where a patient receives multidisciplinary care, within one booked clinic appointment by themselves, one occasion of service shall be recorded, regardless of the number of providers involved.
- Where patients have received more than one booked appointment, each appointment will be counted as one occasion of service. (Example: three booked appointments with all services provided on a single day will be counted as three occasions of service).
- The occasion of service count should be attributed to the clinic type associated with the booked appointment.
- Services to individual patients should be counted separately from services to groups of patients. An occasion of service is counted only for a service provided to an individual. Group sessions are reported separately under 'Establishment - number of group sessions total N[NNNNNN]'.

Source and reference attributes

Submitting organisation: Non-admitted patient NMDS Development Working Party, 2006

Relational attributes

Related metadata references: See also Establishment—outpatient clinic type, code N[N] Health, Standard 04/07/2007

Supersedes Establishment—number of occasions of service, total N[NNNNNN] Health, Superseded 04/07/2007

Implementation in Data Set Specifications: Outpatient care NMDS Health, Standard 04/07/2007

Implementation start date: 01/07/2007

Number of positive sentinel lymph nodes

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—number of positive sentinel lymph nodes, total code N[N]
METeOR identifier:	370549
Registration status:	Health, Standard 06/03/2009
Definition:	The total number of sentinel lymph nodes reported as containing tumour after examination by a pathologist.
Data Element Concept:	Person with cancer—number of positive sentinel lymph nodes

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]
Maximum character length:	3

Supplementary values:

Value	Meaning
997	Number of lymph nodes unknown

Data element attributes

Collection and usage attributes

Collection methods:	For cancer registries: Collection of this data item should only be from notification and pathology reports relating to initial diagnosis and not for recurrent or metastatic disease.
Comments:	Sentinel lymph nodes are the first nodes that filter fluid draining away from the area of cancer. The number of lymph nodes with metastasis is important for cancer staging

Source and reference attributes

Origin:	National Breast and Ovarian Cancer Centre (NBOCC) Australasian Association of Cancer Registries (AACR) Australian Institute of Health and Welfare (AIHW)
Reference documents:	Johnson CH, Adamo M (eds.), SEER Program Coding and Staging Manual 2007. National Cancer Institute, NIH Publication number 07-5581, Bethesda, MD 2007.

Relational attributes

Implementation in Data Set Specifications:	Breast cancer (Cancer registries) DSS Health, Standard 06/03/2009

Number of qualified days for newborns

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care (newborn)—number of qualified days, total N[NNNN]
METeOR identifier:	270033
Registration status:	Health, Standard 01/03/2005
Definition:	The number of qualified newborn days occurring within a newborn episode of care.
Data Element Concept:	Episode of admitted patient care (newborn)—number of qualified days

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNN]
Maximum character length:	5
Unit of measure:	Day

Data element attributes

Collection and usage attributes

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 Episode of admitted patient care—admission date, DDMMYYYY, Episode of admitted patient care—separation date, DDMMYYYY and any Episode of admitted patient care (newborn)—date of change to qualification status, DDMMYYYY:

- 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.

Relational attributes

Related metadata references: Supersedes Number of qualified days for newborns, version 2,

DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.5 KB)

Is formed using Episode of admitted patient care (newborn) — date of change to qualification status, DDMMYYYY Health, Standard 01/03/2005

Is used in the formation of Establishment — number of patient days, total N[N(7)] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Number of regional lymph nodes examined

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—number of regional lymph nodes examined, total code N[N]
METeOR identifier:	370032
Registration status:	Health, Standard 06/03/2009
Definition:	The total number of a person's regional lymph nodes examined by the pathologist.
Data Element Concept:	Person with cancer—number of regional lymph nodes examined

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]
Maximum character length:	3

Supplementary values:

Value	Meaning
997	Number of lymph nodes unknown

Data element attributes

Collection and usage attributes

Guide for use:

A list of which lymph nodes are defined as regional lymph nodes for each cancer site may be found in the TNM Classification of Tumours, 6th Edition, UICC.

The number includes all nodes examined regardless of whether removed/examined at a single or multiple procedures e.g. for breast cancer, record the sum of regional lymph nodes examined from node sampling/sentinel node biopsy and axillary clearance.

The number of regional lymph nodes is cumulative from all procedures that removed lymph nodes through the completion of surgeries for the treatment of the cancer.

Breast cancer:

Regional lymph nodes include all ipsilateral axillary, ipsilateral infraclavicular/subclavicular, ipsilateral internal mammary and ipsilateral supraclavicaular nodes. All other nodes (including contralateral internal mammary nodes) are considered to be distant metastases and should not be recorded in this data item. Defintions from UICC TNM Classification of Malignant Tumours 6th Edition.

Collection methods:

For cancer registries, collection of this data item should only be from notification and pathology reports relating to initial diagnosis and not for recurrent or metastatic disease.

Source and reference attributes

Origin:	Australian Cancer Network
	Commission on Cancer American College of Surgeons
Reference documents:	Australian Cancer Network The pathology reporting of breast cancer. A guide for pathologists, surgeons and radiologists Second Edition Sydney (2001)
	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)
	Johnson CH, Adamo M (eds.), SEER Program Coding and Staging Manual 2007. National Cancer Institute, NIH Publication number 07-5581, Bethesda, MD 2007.

Relational attributes

Related metadata references:	See also Person with cancer—number of positive regional lymph nodes, total N[N] Health, Superseded 06/03/2009
	Supersedes Person with cancer—number of regional lymph nodes examined, total N[N] Health, Superseded 06/03/2009
Implementation in Data Set Specifications:	Breast cancer (Cancer registries) DSS Health, Standard 06/03/2009
	Cancer (clinical) DSS Health, Superseded 22/12/2009
	Cancer (clinical) DSS Health, Standard 22/12/2009

Number of sentinel lymph nodes examined

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—number of sentinel lymph nodes examined, total code N[N]
METeOR identifier:	370558
Registration status:	Health, Standard 06/03/2009
Definition:	The total number of a person's sentinel lymph nodes examined by the pathologist.
Data Element Concept:	Person with cancer—number of sentinel lymph nodes examined

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]
Maximum character length:	3

Supplementary values:

Value	Meaning
997	Number of lymph nodes unknown

Data element attributes

Collection and usage attributes

Collection methods:	For cancer registries, collection of this data item should only be from pathology reports relating to initial diagnosis and not for recurrent or metastatic tumour.
Comments:	Sentinel lymph nodes are the first nodes that filter fluid draining away from the area of cancer. The presence of cancer cells in the lymph nodes indicates that cancer cells have already spread outside the primary site and may have spread to other areas of the body. This is important for cancer staging and treatment options.

Source and reference attributes

Origin:	National Breast and Ovarian Cancer Centre (NBOCC) Australasian Association of Cancer Registries (AACR) Australian Institute of Health and Welfare (AIHW)
Reference documents:	Johnson CH, Adamo M (eds.), SEER Program Coding and Staging Manual 2007. National Cancer Institute, NIH Publication number 07-5581, Bethesda, MD 2007.

Relational attributes

Implementation in Data Set Specifications:	Breast cancer (Cancer registries) DSS Health, Standard 06/03/2009

Number of service contact dates

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—number of service contact dates, total N[NN]
METeOR identifier:	270231
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of dates where a service contact was recorded for the patient/client.
Data Element Concept:	Person—number of service contact dates

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Service contact date

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item 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. For collection from community-based (ambulatory and non-residential) agencies. Includes mental health day programs and psychiatric outpatients.
Comments:	This metadata item gives a measure of the level of service provided to a patient/client.

Source and reference attributes

Submitting organisation:	National Mental Health Information Strategy Committee

Relational attributes

Related metadata references:	Is formed using Service contact—service contact date, DDMMYYYY Health, Standard 01/03/2005 Supersedes Number of service contact dates, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)

Number of service contacts within a treatment episode for alcohol and other drug

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—number of service contacts, total N[NN]
METeOR identifier:	270117
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of service contacts recorded between a client and the service provider within a treatment episode for the purpose of providing alcohol and other drug treatment.
Data Element Concept:	Episode of treatment for alcohol and other drugs—number of service contacts

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Service contact

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item is a count of service contacts related to treatment that are 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 item is not collected for residential clients. Where multiple service provider staff have contact with the client at the same time, on the same occasion of service, the contact is counted only once. When multiple service contacts are recorded on the same day, each independent contact should be counted separately.
Collection methods:	To be collated at the close of a treatment episode.
Comments:	This metadata item provides a measure of the frequency of client contact and service utilisation within a treatment episode.

Source and reference attributes

Submitting organisation: Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references: Supersedes Number of service contacts within a treatment episode for alcohol and other drug, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.6 KB)

Number of service events (non-admitted patient)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of non-admitted patient service events, total N[NNNNNN]
Synonymous names:	Non-admitted patient service event count
METeOR identifier:	270108
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of service events provided to non-admitted patients in the reference period, for each of the clinical service types in the hospital.
Data Element Concept:	Establishment—number of non-admitted patient service events

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Service event

Data element attributes

Collection and usage attributes

Guide for use:

Count of non-admitted patient service events for each of the clinical service types listed in the value domain of the metadata item Non-admitted patient service event—service event type (clinical), code N[N].

For each Non-admitted patient service event count, specify the

- Non-admitted patient service event—service event type (clinical), code N[N]
- Non-admitted patient service event—multi-disciplinary team status, code N
- Service contact—group session status, individual/group session indicator code ANN.N
- Non-admitted patient service event—patient present status, code N
- Non-admitted patient service event—service mode, hospital code N{N}

Comments:

Public patients are defined in accordance with the *1998-2003 Australian Health Care Agreements*.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Non-admitted patient service event count, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.5 KB)

Number of tobacco cigarettes smoked per day after 20 weeks of pregnancy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female (pregnant)—number of cigarettes smoked (per day after 20 weeks of pregnancy), number N[NN]
METeOR identifier:	365445
Registration status:	Health, Standard 03/12/2008
Definition:	The self-reported number of cigarettes usually smoked daily by a pregnant woman after the first 20 weeks of pregnancy until the birth
Context:	Perinatal Statistics
Data Element Concept:	Female (pregnant)—number of cigarettes smoked (after 20 weeks of pregnancy)

Value domain attributes

Representational attributes

Representation class:	Quantity
Data type:	Number
Format:	N[NN]
Maximum character length:	3

Supplementary values:

Value	Meaning
998	Occasional smoking (less than one)
999	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

Data should be collected after the birth.

'After 20 weeks' is defined as greater than or equal to 20 completed weeks' gestation (>=20 weeks + 0 days).

'Usually' is defined as 'according to established, or frequent usage; commonly, ordinarily; as a rule'. If a woman reports having quit smoking at some point between 20 weeks of pregnancy and the birth, the value recorded should be the number of cigarettes usually smoked daily prior to quitting.

Collection methods:

Recommended question: 'How many tobacco cigarettes did the woman usually smoke each day after 20 weeks of pregnancy?', where after 20 weeks of pregnancy is defined as greater than or equal to 20 weeks + 0 days.

If a woman did not smoke tobacco cigarettes at any time after 20 weeks of pregnancy, a value of 000 should be recorded.

Occasional smoking
Women who report that they usually smoked less than one tobacco cigarette per day should have a value recorded of 998.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: See also Female (pregnant) – tobacco smoking indicator (first twenty weeks of pregnancy), yes/no code N Health, Standard 03/12/2008

Implementation in Data Set Specifications: Perinatal NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Conditional obligation:
Record if answer to female (pregnant)-tobacco smoking indicator (after twenty weeks of pregnancy), yes/no code N is Yes

Number of tobacco cigarettes smoked per day first 20 weeks of pregnancy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female (pregnant)—number of cigarettes smoked (per day first 20 weeks of pregnancy), number N[NN]
METeOR identifier:	365441
Registration status:	Health, Standard 03/12/2008
Definition:	The self-reported number of cigarettes usually smoked daily by a woman during the first 20 weeks of pregnancy
Context:	Perinatal Statistics
Data Element Concept:	Female (pregnant)—number of cigarettes smoked (first 20 weeks of pregnancy)

Value domain attributes

Representational attributes

Representation class:	Quantity
Data type:	Number
Format:	N[NN]
Maximum character length:	3

Supplementary values:

Value	Meaning
998	Occasional smoking (less than one)
999	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

Data should be collected after the first 20 weeks of pregnancy; e.g. the next antenatal visit after the first 20 weeks would be an ideal time.

'The first 20 weeks of pregnancy' is defined as less than or equal to 19 weeks + 6 days.

'Usually' is defined as 'according to established, or frequent usage; commonly, ordinarily; as a rule'. If a woman reports having quit smoking at some point during the first 20 weeks of pregnancy, the value recorded should be the number of cigarettes usually smoked daily prior to quitting.

Collection methods:

Recommended question: 'How many tobacco cigarettes did the woman usually smoke during the first 20 weeks of pregnancy?', where the first 20 weeks of pregnancy is defined as less than or equal to 19 weeks + 6 days.

If a woman did not smoke tobacco cigarettes at any time during the first 20 weeks of pregnancy, a value of 000 should be recorded.

Occasional smoking
Women who report that they usually smoked less than one tobacco cigarette per day should have a value recorded of 998.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Nursing diagnosis—other

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—nursing diagnosis (other), code (NANDA 1997-98) N.N[{.N}{.N}{.N}{.N}]
METeOR identifier:	270466
Registration status:	Health, Standard 01/03/2005
Definition:	The nursing diagnosis other than the principal nursing diagnosis, as represented by a code.
Data Element Concept:	Episode of care—nursing diagnosis

Value domain attributes

Representational attributes

Classification scheme:	North American Nursing Diagnosis Association (NANDA) Taxonomy 1997-1998
Representation class:	Code
Data type:	Number
Format:	N.N[{.N}{.N}{.N}{.N}]
Maximum character length:	6

Collection and usage attributes

Guide for use:	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 Minimum Data Set - Australia (CNMDSA).

Data element attributes

Collection and usage attributes

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 or relevance to the current episode.
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.

Comments: The Community Nursing Minimum Data Set - Australia (CNMDSA) Steering Committee considered information from users of the data in relation to this metadata item. 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 North American Nursing Diagnosis Association (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 United States of America project at the University of Iowa which is seeking to refine, extend, validate and classify the NANDA taxonomy.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Relational attributes

Related metadata references: Supersedes Nursing diagnosis, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)

Nursing diagnosis—principal

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—nursing diagnosis (principal), code (NANDA 1997-98) N.N[{.N}{.N}{.N}{.N}]
METeOR identifier:	270220
Registration status:	Health, Standard 01/03/2005
Definition:	The principal nursing diagnosis, as represented by a code.
Data Element Concept:	Episode of care—nursing diagnosis

Value domain attributes

Representational attributes

Classification scheme:	North American Nursing Diagnosis Association (NANDA) Taxonomy 1997-1998
Representation class:	Code
Data type:	Number
Format:	N.N[{.N}{.N}{.N}{.N}]
Maximum character length:	6

Collection and usage attributes

Guide for use:	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 Minimum Data Set - Australia (CNMDSA).

Data element attributes

Collection and usage attributes

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.
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 code set or automated mapping to it when the information is at a more detailed level are equally valid and viable options.

Comments: The Community Nursing Minimum Data Set - Australia (CNMDSA) Steering Committee considered information from users of the data in relation to this metadata item. 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 North American Nursing Diagnosis Association (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 United States of America project at the University of Iowa which is seeking to refine, extend, validate and classify the NANDA taxonomy.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Relational attributes

Related metadata references: Supersedes Nursing diagnosis, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)

Nursing interventions

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Community nursing service episode—nursing intervention, code N
METeOR identifier:	270223
Registration status:	Health, Standard 01/03/2005
Definition:	The nursing action intended to relieve or alter a person's responses to actual or potential health problems, as represented by a code.
Data Element Concept:	Community nursing service episode—nursing intervention

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
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

Collection and usage attributes

Guide for use: The following definitions are to assist in coding:

CODE 1 Coordination and collaboration of care

This code 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).

CODE 2 Supporting information carers

This code 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.

CODE 3 General nursing care

This code 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.

CODE 4 Technical nursing treatment or procedure

This code 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.

CODE 5 Counselling and emotional support

This code 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.

CODE 6 Teaching/education

This code 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.

CODE 7 Monitoring and surveillance

This code 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.

CODE 8 Formal case management

This code 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.

CODE 9 Service needs assessment only

This code is for 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.

Data element attributes

Collection and usage attributes

Guide for use:

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 07 in Community nursing service episode—goal of care, code NN 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 Community Nursing Minimum Data Set Australia (CNMDSA) interventions enabling the option of a rich level of detail of activities or summarised information.

Comments:

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 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 data element Nursing interventions or other more relevant code sets.

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.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Origin: Australian Council of Community Nursing Services 1997. Community Nursing Minimum Data Set Australia (CNMDSA), version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references: Supersedes Nursing interventions, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (24.2 KB)

Occasions of service (residential aged care services)—outreach/community

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (residential aged care service)—number of occasions of service (outreach/community), total N[NN]
METeOR identifier:	270308
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of service delivered by a residential aged care service employees to the patient in the home, place of work or other non-establishment site.
Data Element Concept:	Establishment (residential aged care service)—number of occasions of service

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Comments:	Required to adequately describe the services provided to non-admitted patients. 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.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Type of non-admitted patient care (residential aged care services), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.0 KB)

Occasions of service (residential aged care services)—outpatient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (residential aged care service)—number of occasions of service (outpatient), total N[NN]
METeOR identifier:	270290
Registration status:	Health, Standard 01/03/2005
Definition:	The number of occasions of service delivered by residential aged care service employees. 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.
Data Element Concept:	Establishment (residential aged care service)—number of occasions of service

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Comments:	Required to adequately describe the services provided to non-admitted patients. 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.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Type of non-admitted patient care (residential aged care services), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.0 KB)

Oestrogen receptor assay result

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—oestrogen receptor assay result, code N
METeOR identifier:	370036
Registration status:	Health, Standard 06/03/2009
Definition:	The result of oestrogen receptor assay at the time of diagnosis of the primary breast tumour, as represented by a code.
Data Element Concept:	Person with cancer—oestrogen receptor assay result

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values: / *Supplementary values:*

Value	Meaning
1	Positive
2	Negative
3	Equivocal
7	Unknown (test results not available)
8	Not applicable (test not done)

Collection and usage attributes

Guide for use:

Supplementary codes

CODE 7 Unknown (test results not available)

Use this code when the test has been performed but the results are not yet available for analysis.

CODE 8 Not applicable (test not done)

This code is used as a validation measure, to show that the reason for the lack of results is due to the test not being performed.

Data element attributes

Collection and usage attributes

Guide for use:

Where the pathologist has stated the test result in the conclusion of the pathology report as being positive, negative or equivocal this value should be coded. If the report does not specifically state the test result, this should be interpreted from the reported % nuclei stained positive. If => 1% of nuclei are reported as stained regardless of stain intensity (weak, intermediate or high/strong) the result is positive. If % nuclei stained is <1% the

result is negative. Definitions from NBOCC & ACN Pathology Reporting Guidelines.

Collection methods:

For cancer registries:

Collection of this data item should only be from notification and pathology reports relating to initial diagnosis and not for recurrent or subsequent metastatic disease.

Where there are multiple reports relating to the primary breast tumour (from different specimens), the 'most positive' value is chosen according to the following hierarchy: Positive > Equivocal > Negative> Test done but results not known > Test not done.

If oestrogen receptor assay tests are completed for invasive tumours with an in situ component, use the values from the invasive tumour.

Do not record oestrogen receptor values for in situ tumours.

For multifocal tumours, use the oestrogen receptor value from the largest focus or from a metastatic deposit, e.g. Lymph node metastasis. A smaller focus that is ER positive may in fact be the source of a metastasis and in this setting the patient would derive benefit from the therapy offered as a result of hormone receptor positive status.

Comments:

Hormone receptor status is an important prognostic indicator for breast cancer.

The Australian Cancer Network Working Party established to develop guidelines for the pathology reporting of breast cancer recommends that hormone receptor assays be performed on all cases of invasive breast carcinoma. The report should include

- the percentage of nuclei staining positive and the predominant staining intensity (low, medium, high) and
- a conclusion as to whether the assay is positive or negative.

Source and reference attributes

Origin:

Royal College of Pathologists of Australasia

Australian Cancer Network

Commission on Cancer American College of Surgeons

Reference documents:

Royal College of Pathologists of Australasia Manual of Use and Interpretation of Pathology Tests: Third Edition Sydney (2001)

Australian Cancer Network Working Party The pathology reporting of breast cancer. A guide for pathologists, surgeons and radiologists Second Edition Sydney (2001)

Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:

Supersedes Person with cancer—oestrogen receptor assay results, code N Health, Superseded 06/03/2009

Implementation in Data Set Specifications:

Breast cancer (Cancer registries) DSS Health, Standard 06/03/2009

Cancer (clinical) DSS Health, Superseded 22/12/2009

Cancer (clinical) DSS Health, Standard 22/12/2009

Onset of labour

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—labour onset type, code N
METeOR identifier:	269942
Registration status:	Health, Standard 01/03/2005
Definition:	The manner in which labour started in a birth event, as represented by a code.
Data Element Concept:	Birth event—labour onset type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Spontaneous
2	Induced
3	No labour

Supplementary values:

4	Not stated

Collection and usage attributes

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.

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.

CODE 3 No labour
Can only be associated with a caesarean section.

Data element attributes

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Onset of labour, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.6 KB)
Implementation in Data Set Specifications:	Perinatal NMDS Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Perinatal NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Perinatal NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Ophthalmological assessment—outcome (left retina)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—ophthalmological assessment outcome (left retina) (last 12 months), code N
METeOR identifier:	270472
Registration status:	Health, Standard 01/03/2005
Definition:	The result of an ophthalmological assessment for the left retina during the last 12 months, as represented by a code.
Data Element Concept:	Person—ophthalmological assessment outcome

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Normal
2	Diabetes abnormality
3	Non-diabetes abnormality
4	Not visualised

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

This is a repeating record of both eyes.

1st field - Right retina

2nd field - Left retina

Record the result of the fundus examination for each eye as: Normal/ Diabetes abnormality/ Non-diabetes abnormality/ or Not visualised.

Example:

- code 12 for right retina Normal and left retina Diabetes abnormality
- code 32 for right retina Non-diabetes abnormality and left retina Diabetes abnormality

Only the result of an assessment carried out in the last 12 months should be recorded.

Collection methods: Ophthalmological assessment should be performed by an

ophthalmologist or a suitably trained clinician.

A comprehensive ophthalmological examination includes:

- Checking visual acuity with Snellen chart - correct with pinhole if indicated;
- Examination for cataract;
- Examination of fundi with pupils dilated.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references: See also Person—ophthalmological assessment outcome (right retina) (last 12 months), code N Health, Standard 01/03/2005

Supersedes Ophthalmological assessment - outcome, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.5 KB)

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Ophthalmological assessment—outcome (right retina)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—ophthalmological assessment outcome (right retina) (last 12 months), code N
METeOR identifier:	270363
Registration status:	Health, Standard 01/03/2005
Definition:	The result of an ophthalmological assessment for the right retina during the last 12 months, as represented by a code.
Data Element Concept:	Person—ophthalmological assessment outcome

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Normal
2	Diabetes abnormality
3	Non-diabetes abnormality
4	Not visualised

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

This is a repeating record of both eyes.

1st field - Right retina

2nd field - Left retina

Record the result of the fundus examination for each eye as: Normal/ Diabetes abnormality/ Non-diabetes abnormality/ or Not visualised.

Example:

- code 12 for right retina Normal and left retina Diabetes abnormality
- code 32 for right retina Non-diabetes abnormality and left retina Diabetes abnormality

Only the result of an assessment carried out in the last 12 months should be recorded.

Collection methods: Ophthalmological assessment should be performed by an

ophthalmologist or a suitably trained clinician.

A comprehensive ophthalmological examination includes:

- Checking visual acuity with Snellen chart - correct with pinhole if indicated;
- Examination for cataract;
- Examination of fundi with pupils dilated.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references: See also Person—ophthalmological assessment outcome (left retina) (last 12 months), code N Health, Standard 01/03/2005

Supersedes Ophthalmological assessment - outcome, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.5 KB)

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Ophthalmoscopy performed indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—ophthalmoscopy performed indicator (last 12 months), code N
METeOR identifier:	302821
Registration status:	Health, Standard 21/09/2005
Definition:	Whether or not an examination of the fundus of the eye by an ophthalmologist or optometrist, as a part of the ophthalmological assessment, has been undertaken in the last 12 months, as represented by a code.
Data Element Concept:	Person—ophthalmoscopy performed indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes: Record if a fundus examination of eye has occurred. CODE 2 No: Record if a fundus examination of eye has not occurred.
Collection methods:	Ask the individual if he/she has undertaken an eye check, including examination of fundi with pupils dilated. Pupil dilatation and an adequate magnified view of the fundus is essential, using either detailed direct or indirect ophthalmoscopy or fundus camera. This will usually necessitate referral to an ophthalmologist.

Source and reference attributes

Submitting organisation:	National diabetes data working group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references: Supersedes Person—ophthalmoscopy performed status (previous 12 months), code N Health, Superseded 21/09/2005

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Standard 21/09/2005

Organisation end date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—organisation end date, DDMMYYYY
METeOR identifier:	288733
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The date on which an establishment, agency or organisation stopped or concluded operations or practice.
Data Element Concept:	Service provider organisation—organisation end date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Relational attributes

Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007
	Health care provider identification DSS Health, Superseded 03/12/2008
	Health care provider identification DSS Health, Standard 03/12/2008

Organisation expenses, total Australian currency

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Organisation—expenses, total Australian currency NNNNN.N
METeOR identifier:	359963
Registration status:	Health, Standard 05/12/2007
Definition:	Expenses of an organisation consisting mainly of wages, salaries and supplements, superannuation employer contributions, workers compensation premiums and payouts, purchases of goods and services and consumption of fixed capital (depreciation), in Australian currency.
Data Element Concept:	Organisation—expenses

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	NNNNN.N
Maximum character length:	6
Unit of measure:	Australian currency (AU$)

Source and reference attributes

Submitting organisation:	Health Expenditure Advisory Committee

Data element attributes

Collection and usage attributes

Guide for use:

Data are collected and nationally collated for the reporting period - the financial year ending 30th June each year.

Expenses are to be reported in millions to the nearest 100,000 e.g. $4,064,000 should be reported as $4.1 million.

When revenue from transactions are offset against expenses from transactions, the result equates to the net operating balance in accordance with Australian Accounting Standards Board 1049 (September 2006).

Includes:

- Salaries, wages and supplements
- Superannuation employer contributions
- Workers compensation premiums and payments
- Consumption of fixed capital (depreciation).
- Administrative expenses (excluding workers compensation premiums and payouts)
- Domestic services

- Drug supplies
- Food supplies
- Grants
- Medical and surgical supplies
- Patient transport
- Payments to visiting medical officers
- Repairs and maintenance
- Social benefits
- Subsidy expenses
- Other expenses

Collection methods:

Expenses are to be reported for the *Health industry relevant organisation type* and *Typeof health and health related functions* data elements.

Health industry relevant organisation type

State and territory health authorities are **NOT** to report the following codes:

Codes 106–109; 111; 115–119; 123; 201 and 203

Type of health and health related functions

State and territory health authorities are **NOT** to report the following codes:

Codes 199; 299; 303–305; 307; 499; 503–504; 599; 601–603; 688; 699

Comments:

In accounting terms, expenses are consumptions or losses of future economic benefits in the form of reductions in assets or increases in liabilities of the entity (other than those relating to distributions to owners) that result in a decrease in equity or net worth during the reporting period.

Source and reference attributes

Submitting organisation:

Health Expenditure Advisory Committee

Origin:

Australian Bureau of Statistics: Government Finance Statistics 1998, Cat. No. 5514.0.

Australian Bureau of Statistics 2006. Australian System of Government Finance Statistics: Concepts, sources and methods, 2005. Cat. no. 5514.0.55.001 Canberra: ABS.

Australian Accounting Standards Board 1049, September 2006, reference: http://www.aasb.com.au/

Relational attributes

Related metadata references:

Is formed using Organisation—employee related expenses, total Australian currency NNNNN.N Health, Standard 05/12/2007

Is formed using Organisation—purchase of goods and services, total Australian currency NNNNN.N Health, Standard 05/12/2007

Is formed using Organisation—capital consumption expenses, total Australian currency NNNNN.N Health, Standard 01/04/2009

Implementation in Data Set

Government health expenditure organisation expenditure data

Specifications:	cluster Health, Superseded 03/12/2008
	Government health expenditure organisation expenditure data element cluster Health, Superseded 01/04/2009
	Government health expenditure organisation expenditure data element cluster Health, Standard 01/04/2009

Organisation name

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (name)—organisation name, text [X(200)]
METeOR identifier:	288917
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The appellation by which an establishment, agency or organisation is known or called, as represented by text.
Data Element Concept:	Service provider organisation (name)—organisation name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(200)]
Maximum character length:	200

Data element attributes

Collection and usage attributes

Guide for use:	Generally, the complete establishment, agency or organisation name should be used to avoid any ambiguity in identification. This should usually be the same as company registration name. However, in certain circumstances (e.g. internal use), a short name (i.e. an abbreviated name by which the organisation is known) or a locally used name (e.g. where a medical practice is known by a name that is different to the company registration name) can be used. Further, a business unit within an organisation may have its own separate identity; this should be captured (as the unit name – see Organisation name type). More than one name can be recorded for an organisation. That is, this field is a multiple occurring field. At least one organisation name must be recorded for each organisation and each name must have an appropriate Organisation name type.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Implementation in Data Set	Health care provider identification DSS Health, Superseded

Specifications:	04/07/2007
	Health care provider identification DSS Health, Superseded 03/12/2008
	Health care provider identification DSS Health, Standard 03/12/2008

Organisation revenues

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Organisation—revenue, total Australian currency NNNNN.N
METeOR identifier:	357510
Registration status:	Health, Standard 05/12/2007
Definition:	Revenues of an organisation relating to **patient fees**, **recoveries**, and **other revenue** in Australian currency.
Data Element Concept:	Organisation—revenue

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	NNNNN.N
Maximum character length:	6
Unit of measure:	Australian currency (AU$)

Source and reference attributes

Submitting organisation:	Health Expenditure Advisory Committee

Data element attributes

Collection and usage attributes

Guide for use:

Revenues are to be reported in millions to the nearest 100,000 e.g. $4,064,000 should be reported as $4.1 million.

Revenue arises from:

- the sale of goods,
- the rendering of services, and
- the use by others of entity assets yielding interest, royalties and dividends.

Goods includes goods produced by the entity for the purpose of sale and goods purchased for resale, such as merchandise purchased by a retailer or land and other property held for resale.

The rendering of services typically involves the performance by the entity of a contractually agreed task over an agreed period of time. The services may be rendered within a single period or over more than one period. Some contracts for the rendering of services are directly related to construction contracts, for example, those for the services of project managers and architects. Revenue arising from these contracts is not dealt with in this Standard but is dealt with in accordance with the requirements for construction contracts as specified in AASB 111

Construction Contracts.

The use by others of entity assets gives rise to revenue in the form of:

(a) interest – charges for the use of cash or cash equivalents or amounts due to the entity;

(b) royalties – charges for the use of long-term assets of the entity, for example, patents, trademarks, copyrights and computer software; and

(c) dividends – distributions of profits to holders of equity investments in proportion to their holdings of a particular class of capital.

Revenue is the gross inflow of economic benefits during the period arising in the course of the ordinary activities of an entity when those inflows result in increases in equity, other than increases relating to contributions from equity participants.

Revenue includes only the gross inflows of economic benefits received and receivable by the entity on its own account.

Amounts collected on behalf of third parties such as sales taxes, goods and services taxes and value added taxes are not economic benefits which flow to the entity and do not result in increases in equity. Therefore, they are excluded from revenue. Similarly, in an agency relationship, the gross inflows of economic benefits include amounts collected on behalf of the principal and which do not result in increases in equity for the entity. The amounts collected on behalf of the principal are not revenue. Instead, revenue is the amount of commission.

Collection methods:

Revenues are to be reported for the *Source of public and private revenue* and *Health industry relevant organisation type* data elements.

Source of public and private revenue

State and territory health authorities are NOT to report the following codes:

Codes 101–103; 204; 207; 301

Health industry relevant organisation type

State and territory health authorities are NOT to report the following codes:

Codes 106–109; 111; 115–119; 123; 201 and 203

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Reference documents: ABS 2003. Australian System of Government Finance Statistics: Concepts, Sources and Methods (Cat. no. 5514.0.55.001) 10/10/2003.

Australian Accounting Standards Board 118, July 2007, <www.aasb.com.au>.

Relational attributes

Implementation in Data Set Government health expenditure function revenue data cluster

Specifications:	Health, Superseded 03/12/2008
	Government health expenditure function revenue data element cluster Health, Standard 03/12/2008
	Government health expenditure organisation revenue data element cluster Health, Superseded 03/12/2008
	Government health expenditure organisation revenue data element cluster Health, Superseded 01/04/2009
	Government health expenditure organisation revenue data element cluster Health, Standard 01/04/2009

Organisation start date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—organisation start date, DDMMYYYY
METeOR identifier:	288963
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The date on which an establishment, agency or organisation started or commenced operations or service.
Data Element Concept:	Service provider organisation—organisation start date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use: This field must—

- be a valid date;
- be less than or equal to the Organisation end date.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007
	Health care provider identification DSS Health, Superseded 03/12/2008
	Health care provider identification DSS Health, Standard 03/12/2008

Other drug of concern

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—drug of concern (other), code (ASCDC 2000 extended) NNNN
METeOR identifier:	270110
Registration status:	Health, Standard 01/03/2005
Definition:	A drug apart from the principal drug of concern which the client states as being a concern, as represented by a code.
Data Element Concept:	Episode of treatment for alcohol and other drugs—drug of concern

Value domain attributes

Representational attributes

Classification scheme:	Australian Standard Classification of Drugs of Concern 2000
Representation class:	Code
Data type:	String
Format:	NNNN
Maximum character length:	4

Supplementary values:

Value	Meaning
0005	Opioid analgesics not further defined
0006	Psychostimulants not further defined

Collection and usage attributes

Guide for use:

The Australian Standard Classification of Drugs of Concern (ASCDC) provides a number of supplementary codes that have specific uses and these are detailed within the ASCDC e.g. 0000 = inadequately described.

Other supplementary codes that are not already specified in the ASCDC may be used in National Minimum Data Sets (NMDS) when required. In the Alcohol and other drug treatment service NMDS, two additional supplementary codes have been created which enable a finer level of detail to be captured:

CODE 0005 Opioid analgesics not further defined

This code is to be used when it is known that the client's principal drug of concern is an opioid but the specific opioid used is not known. The existing code 1000 combines opioid analgesics and non-opioid analgesics together into Analgesics nfd and the finer level of detail, although known, is lost.

CODE 0006 Psychostimulants not further defined

This code is to be used when it is known that the client's principal drug of concern is a psychostimulant but not which type. The existing code 3000 combines stimulants and

hallucinogens together into Stimulants and hallucinogens nfd and the finer level of detail, although known, is lost.

Psychostimulants refer to the types of drugs that would normally be coded to 3100-3199, 3300-3399 and 3400-3499 categories plus 3903 and 3905.

Data element attributes

Collection and usage attributes

Guide for use:

Record each additional drug of concern (according to the client) relevant to the treatment episode. The other drug of concern does not need to be linked to a specific treatment type.

More than one drug may be selected. There should be no duplication with the principal drug of concern.

Collection methods:

Any other drug of concern for the client should be recorded upon commencement of a treatment episode.

For clients whose treatment episode is related to the alcohol and other drug use of another person, this metadata item should not be collected.

Comments:

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.

Source and reference attributes

Submitting organisation:

Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references:

Supersedes Other drug of concern, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.4 KB)

Implementation in Data Set Specifications:

Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Alcohol and other drug treatment services NMDS 2010-2011
Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Other treatment type for alcohol and other drugs

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—treatment type (other), code [N]
METeOR identifier:	270076
Registration status:	Health, Standard 01/03/2005
Definition:	All other forms of treatment provided to the client in addition to the main treatment type for alcohol and other drugs, as represented by a code.
Data Element Concept:	Episode of treatment for alcohol and other drugs—treatment type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	[N]
Maximum character length:	1

Permissible values:

Value	Meaning
1	Withdrawal management (detoxification)
2	Counselling
3	Rehabilitation
4	Pharmacotherapy
5	Other

Collection and usage attributes

Guide for use:

CODE 1 Withdrawal management (detoxification)

Refers to any form of withdrawal management, including medicated and non-medicated.

CODE 2 Counselling

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 Rehabilitation

Refers to an intensive treatment program that integrates a range of services and therapeutic activities that may include counselling, 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. Counselling that is

included within an overall rehabilitation program should be coded to Code 3 for Rehabilitation, not to Code 2 as a separate treatment episode for counselling.

CODE 4 Pharmacotherapy

Refers to pharmacotherapies that include those used as maintenance therapies (e.g. naltrexone, buprenorphine, and methadone treatment) and those used as relapse prevention. Use Code 1 (withdrawal management) where a pharmacotherapy is used solely for withdrawal. Note collection exclusions: excludes clients who are on an opioid pharmacotherapy maintenance program and are not receiving any other form of treatment.

Data element attributes

Collection and usage attributes

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 other drugs of concern.

More than one code may be selected.

Collection methods:

This field should be left blank if there are no other treatment types for the episode.

Comments:

Information about treatment provided is of fundamental importance to service delivery and planning.

Source and reference attributes

Submitting organisation:

Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references:

Supersedes Other treatment type for alcohol and other drugs, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.7 KB)

Implementation in Data Set Specifications:

Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2010
Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Alcohol and other drug treatment services NMDS 2010-2011
Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Other/Underlying cause of acute coronary syndrome

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with acute coronary syndrome—underlying cause of acute coronary syndrome, code N
Synonymous names:	Secondary cause of ACS
METeOR identifier:	338310
Registration status:	Health, Standard 01/10/2008
Definition:	The condition or event, other than the usual risk factors, which has caused a person's acute coronary syndrome symptoms, as represented by a code
Data Element Concept:	Person—underlying cause of acute coronary syndrome

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N[N]	
Maximum character length:	9	
Permissible values:	Value	Meaning
	1	Anaemia
	2	Severe valvular disease
	3	Thyrotoxicosis
	4	Fever
	5	Hypoxaemia
	6	Trauma
	7	Surgery
Supplementary values:	88	Other
	99	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Collection methods:	This is to be recorded by the clinician.
Comments:	This identifies whether the person experiencing acute coronary syndrome (ACS) symptoms is doing so due to another condition or event and where the treatment would be primarily targeted at managing that condition. The presence of one of these conditions or events has a significant impact on the appropriate treatment modalities for ACS. Therefore, the person's treatment may be different from those recommended for ACS.

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Outcome of initial treatment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—outcome of treatment, code N.N
METeOR identifier:	289304
Registration status:	Health, Standard 04/06/2004
Definition:	The response of the tumour at the completion of the initial treatment modalities, as represented by a code.
Data Element Concept:	Cancer treatment—outcome of treatment

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N.N
Maximum character length:	2

Permissible values:

Value	Meaning
1.0	Complete response
2.1	Partial response
2.2	Stable or static disease
2.3	Progressive disease
2.9	Incomplete response

Supplementary values:

9.0	Not assessed or unable to be assessed

Collection and usage attributes

Guide for use:

CODE 1.0 Complete response

Complete disappearance of all measurable disease, including tumour markers, for at least four weeks. No new lesions or new evidence of disease.

CODE 2.1 Partial response

A decrease by at least 50% of the sum of the products of the maximum diameter and perpendicular diameter of all measurable lesions, for at least four weeks. No new lesions or worsening of disease.

CODE 2.2 Stable or static disease

No change in measurable lesions qualifying as partial response or progression and no evidence of new lesions.

CODE 2.3 Progressive disease

An increase by at least 25% of the sum of the products of the maximum diameter and a perpendicular diameter of any measurable lesion, or the appearance of new lesions.

Data element attributes

Source and reference attributes

Origin:	New South Wales Health Department
Reference documents:	Public Health Division NSW Clinical Cancer Data Collection for Outcomes and Quality. Data Dictionary Version 1 Sydney NSW Health Dept (2001)

Relational attributes

Related metadata references:	Supersedes Outcome of initial treatment, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.8 KB)
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005
	Cancer (clinical) DSS Health, Superseded 06/03/2009
	Cancer (clinical) DSS Health, Superseded 22/12/2009
	Cancer (clinical) DSS Health, Standard 22/12/2009

Outcome of last previous pregnancy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Pregnancy (last previous)—pregnancy outcome, code N
METeOR identifier:	270006
Registration status:	Health, Standard 01/03/2005
Definition:	Outcome of the most recent pregnancy preceding this pregnancy, as represented by a code.
Data Element Concept:	Pregnancy (last previous)—pregnancy outcome

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
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

Data element attributes

Collection and usage attributes

Guide for use:	In the case of multiple pregnancy with fetal loss before 20 weeks, code on outcome of surviving fetus(es) beyond 20 weeks.
Comments:	This data item is recommended by the World Health Organization. It is collected in some states and territories. Adverse outcome in previous pregnancy is an important risk factor for subsequent pregnancy.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Outcome of last previous pregnancy, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Outpatient clinic type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—outpatient clinic type, code N[N]
METeOR identifier:	336952
Registration status:	Health, Standard 04/07/2007
Definition:	The organisational unit or organisational arrangement through which a hospital provides healthcare services in an outpatient setting, as represented by a code.
Data Element Concept:	Establishment—outpatient clinic type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	Allied Health
2	Dental
3	Gynaecology
4	Obstetrics
5	Cardiology
6	Endocrinology
7	Oncology
8	Respiratory
9	Gastroenterology
10	Medical
11	General practice/primary care
12	Paediatric medical
13	Endoscopy
14	Plastic surgery
15	Urology
16	Orthopaedic surgery
17	Ophthalmology
18	Ear, nose and throat
19	Pre-admission and pre-anaesthesia
20	Chemotherapy
21	Dialysis
22	Surgery

23	Paediatric surgery
24	Renal medical

Collection and usage attributes

Guide for use:

The rules for allocating (mapping) clinic services to the clinic codes structure is the responsibility of each State and Territory and these rules need to be applied consistently within each State and Territory.

In most cases, reference to the code guide of permissible values will be adequate to map a hospital's clinics to the data domain. If not, general principles for mapping existing clinics to the data domain should take account of (a) the nature of the specialty, (b) patient characteristics, e.g. age, and (c) the field of practice of the service provider.

Where the patient characteristics have determined that a paediatric clinic type is appropriate, then further differentiation between surgical and medical is determined by (a) the nature of the specialty, and (b) the field of practice of the service provider. That is, paediatric medical would include any investigations, treatment(s) or services provided to a child which do not pertain to the surgical care of diseases or injuries.

In paediatric hospitals, the full range of clinic types should be used.

A guide for the permissible values of codes for the outpatient clinic types is as follows:

CODE 1 Allied Health

- Audiology.
- Clinical Pharmacology.
- Neuropsychology.
- Dietetics.
- Occupational therapy.
- Optometry.
- Orthoptics.
- Orthotics.
- Physiotherapy.
- Podiatry.
- Prosthetics.
- Psychology.
- Social work.
- Speech pathology.

Includes clinics specified in mapping list above run solely by these Allied Health (AH) professionals. Example: A speech Pathologist conducting a clinic with booked patients for speech pathology services.

Excludes services provided by AH professionals in clinics classified in codes 2-23. Example: a physiotherapist running a

cardiac rehabilitation clinic is classified to the Cardiology Clinic (see code 5).

CODE 2 Dental

- Dental.

CODE 3 Gynaecology

- Gynaecology.
- Gynaecological oncology (excluding chemotherapy).
- Menopause.
- Assisted reproduction, infertility.
- Family planning.

CODE 4 Obstetrics

- Obstetrics.
- Childbirth education.
- Antenatal.
- Postnatal.

Excludes gestational diabetes (see code 6).

CODE 5 Cardiology

- Cardiac rehabilitation.
- ECG.
- Doppler.
- Cardiac stress test.
- Hypertension.
- Pacemaker.

Excludes cardiac catheterisation (see code 22).

CODE 6 Endocrinology

- Endocrine.
- Gestational diabetes.
- Thyroid.
- Metabolic.
- Diabetes.
- Diabetes education.

CODE 7 Oncology

- Oncology.
- Lymphoedema.
- Radiation oncology.

Excludes chemotherapy (see code 20).

Excludes gynaecological oncology (see code 3).

CODE 8 Respiratory

- Asthma.
- Asthma education.
- Respiratory; excludes tuberculosis (see code 10).

- Cystic Fibrosis.
- Sleep.
- Pulmonary.

CODE 9 Gastroenterology

- Gastroenterology.

Excludes endoscopy (see code 13).

CODE 10 Medical

- Aged care, geriatric, gerontology.
- Allergy.
- Anti-coagulant.
- Clinical Measurement; include with relevant specialty clinic type where clinical measurement services are specific to a specialty (see codes 1-23) e.g. urodynamic analysis is counted with Urology (see code 15).
- Dementia.
- Dermatology.
- Development disability.
- Epilepsy.
- Falls.
- General medicine.
- Genetic.
- Haematology, haemophilia.
- Hepatobiliary.
- Hyperbaric medicine.
- Immunology, HIV.
- Infectious diseases; Communicable diseases; Hep B, C; includes tuberculosis.
- Men's Health.
- Metabolic bone.
- Excludes Nephrology (see code 24); excludes renal (see code 24); excludes dialysis (see code 21).
- Neurology, neurophysiology.
- Occupational medicine.
- Other.
- Pain management
- Palliative.
- Refugee clinic.
- Rehabilitation; excludes cardiac rehabilitation (see code 5).
- Rheumatology.
- Sexual Health.
- Spinal.

- Stoma therapy.
- Transplants (excludes kidney transplants see code 24).
- Wound, Dressing clinic.

CODE 11 General practice/primary care

- General Practice, Primary Care.

Excludes Medicare billable patients; defined specialty general practice clinics only.

CODE 12 Paediatric Medical

- Adolescent health.
- Neonatology.
- Paediatric medicine.

In paediatric hospitals the full range of service types should be used. That is, paediatric medical should be reported as medical and paediatric surgery should be reported as surgery.

CODE 13 Endoscopy

Includes all occasions of service for endoscopy including cystoscopy, gastroscopy, oesophagoscopy, duodenoscopy, colonoscopy, bronchoscopy, laryngoscopy and sigmoidoscopy.

Care must be taken to ensure procedures for admitted patients are excluded from this category.

CODE 14 Plastic surgery

- Craniofacial.
- Melanoma.
- Plastic surgery.

CODE 15 Urology

- Urology.

Includes urodynamic measurement and IVPs.

CODE 16 Orthopaedic surgery

- Fracture.
- Hand.
- Orthopaedics Surgery.
- Other.
- Scoliosis.
- Neck of femur.

CODE 17 Ophthalmology

- Ophthalmology.
- Cataract extraction.
- Lens insertion.

CODE 18 Ear, nose and throat

- Ear, nose and throat.
- Otitis media.
- Oral.

CODE 19 Pre-admission and pre-anaesthesia

- Pre-admission.
- Pre-anaesthesia.

CODE 20 Chemotherapy

Includes all forms of chemotherapy.

CODE 21 Dialysis

Dialysis and includes renal dialysis education. See code 24 for Renal medicine

CODE 22 Surgery

- Cardiac.
- Vascular.
- Cardiac catheterisation.
- Colorectal.
- Upper GI surgery.
- General surgery.
- Neurosurgery.
- Other surgery.
- Thoracic surgery.

CODE 23 Paediatric surgery

In paediatric hospitals the full range of service types should be used. That is, paediatric medical should be reported as medical and paediatric surgery should be reported as surgery.

CODE 24 Renal Medical

- Renal Medicine.
- Nephrology.
- Includes pre and post transplant treatment, support and education.
- Excludes dialysis and renal dialysis education. See code 21.

Source and reference attributes

Origin: National Centre for Classification in Health consultant's report to Outpatients National Minimum Data Set Development Working Group, September 2004.

Data element attributes

Collection and usage attributes

Guide for use: Does not include services provided through community health settings (such as community and child health centres).

Source and reference attributes

Submitting organisation: Non-admitted patient NMDS Development Working Group, 2006

Relational attributes

Related metadata references:

See also Establishment—number of occasions of service, total N[NNNNNN] Health, Standard 04/07/2007

Supersedes Establishment—outpatient clinic type, code N[N] Health, Superseded 04/07/2007

Implementation in Data Set Specifications:

Outpatient care NMDS Health, Standard 04/07/2007

Implementation start date: 01/07/2007

Overdue patient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—overdue patient status, code N
METeOR identifier:	270009
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a patient is an overdue patient, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode—overdue patient status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Overdue patient
2	Other

Data element attributes

Collection and usage attributes

Guide for use:

This metadata item is only required for patients in Elective surgery waiting list episode—clinical urgency, code N 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 Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] or Elective surgery waiting list episode —waiting time (at a census date), total days N[NNN] and the maximum desirable time limit for the Elective surgery waiting list episode—clinical urgency, code N 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 Elective surgery waiting list episode—clinical urgency, code N category 1 or 90 days for patients in Elective surgery waiting list episode—clinical urgency, code N category 2.

Comments:

This metadata item is not used for patients in Elective surgery waiting list episode—clinical urgency, code N category 3 as there is no specified timeframe within which it is desirable that they

are admitted. The metadata item Elective surgery waiting list episode—extended wait patient indicator, status code N identifies patients in Elective surgery waiting list episode—clinical urgency, code N category 3 who have waited longer than one year at admission or at the time of a census.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

See also Elective surgery waiting list episode—clinical urgency, code N Health, Standard 01/03/2005

Is formed using Elective surgery waiting list episode—waiting time (at a census date), total days N[NNN] Health, Standard 01/03/2005

Is formed using Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] Health, Standard 01/03/2005

Supersedes Overdue patient, version 3, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.4 KB)

Implementation in Data Set Specifications:

Elective surgery waiting times (census data) NMDS Health, Superseded 07/12/2005

Implementation start date: 30/09/2002

Implementation end date: 30/06/2006

Elective surgery waiting times (census data) NMDS 2006-2009 Health, Superseded 03/12/2008

Implementation start date: 30/09/2006

Implementation end date: 31/03/2009

Elective surgery waiting times (census data) NMDS 2009- Health, Standard 03/12/2008

Implementation start date: 30/06/2009

Elective surgery waiting times (removals data) NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2002

Implementation end date: 30/06/2006

Elective surgery waiting times (removals data) NMDS 2006-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2006

Implementation end date: 30/06/2009

Elective surgery waiting times (removals data) NMDS 2009- Health, Standard 03/12/2008

Implementation start date: 01/07/2009

Palliative care agency service delivery setting

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—service delivery setting, palliative care agency code N
METeOR identifier:	297661
Registration status:	Health, Standard 05/12/2007
Definition:	The setting in which a **palliative care agency** delivers palliative care services, as represented by a code.
Data Element Concept:	Service provider organisation—service delivery setting

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Private residence
2	Residential - aged care setting
3	Residential - other setting
4	Non-residential setting
5	Inpatient - designated palliative care unit or hospice
6	Inpatient - other than a designated palliative care unit
7	Outpatient - in a hospital/hospice

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Private residence

This may include a caravan, a mobile home, a houseboat or a unit in a retirement village.

CODE 2 Residential - aged care setting

Includes high and low care residential aged care facilities. Does not include units in a retirement village.

CODE 3 Residential - other setting

Includes a residential facility other than an aged care facility; a prison; or a community living environment including a group home. This code does not include inpatient settings e.g. hospitals and hospices.

CODE 4 Non-residential setting

Includes day respite centres and day centres. It does not include hospital outpatient departments.

CODE 5 Inpatient - designated palliative care unit or hospice

A dedicated ward or unit that receives identified funding for palliative care and/or primarily delivers palliative care. The unit may be a standalone unit (i.e. a hospice).

CODE 6 Inpatient - other than designated palliative care unit

Includes all beds not in a unit designated for palliative care. These are usually located in acute hospital wards. Excludes designated palliative care units.

CODE 7 Outpatient - in a hospital/hospice

Includes palliative care services provided at a hospital/hospice in an outpatient setting. Excludes all inpatient settings.

Collection methods: More than one code can be recorded.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications: Palliative care performance indicators DSS Health, Standard 05/12/2007

Parity

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—parity, total N[N]
METeOR identifier:	302013
Registration status:	Health, Standard 29/11/2006
Definition:	The total number of previous pregnancies experienced by the woman that have resulted in a live birth or a stillbirth.
Data Element Concept:	Female—parity

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	N[N]	
Maximum character length:	2	
Supplementary values:	Value	Meaning
	99	Not stated
Unit of measure:	Pregnancy	

Data element attributes

Collection and usage attributes

Guide for use:

This is to be recorded for each pregnancy.

This data element includes live births and stillbirths of 20 weeks gestation or 400 grams birthweight.

This data element excludes:

- the current pregnancy;
- pregnancies resulting in spontaneous or induced abortions before 20 weeks gestation; and
- ectopic pregnancies.

A primigravida (a woman pregnant for the first time) has a parity of 0.

Collection methods:

A pregnancy with multiple fetuses is counted as one pregnancy.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Partner organisation type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—partner organisation type, palliative care code N[N]
METeOR identifier:	290715
Registration status:	Health, Standard 05/12/2007
Definition:	The type of organisation with which a palliative care service provider organisation has formal working partnership(s) in place, as represented by a code.
Data Element Concept:	Service provider organisation—partner organisation type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	Palliative care services
2	Hospitals
3	Community nursing agencies
4	Residential aged care facilities
5	Allied health services
6	Aboriginal health services
7	Medical practices
8	Integrated health centres
9	Universities/research centres
10	Volunteer support services
99	Other

Data element attributes

Collection and usage attributes

Guide for use:

A formal working partnership involves arrangements between a service provider organisation and other service providers and organisations, aimed at providing integrated and seamless care, so that clients are able to move smoothly between services and service settings.

A formal working partnership is a verbal or written agreement between two or more parties. It specifies the roles and responsibilities of each party, including the expected outcomes of the agreement.

Key elements of a formal working partnership are that it is organised, routine, collaborative, and systematic. It excludes ad hoc arrangements. Examples of formal working partnerships include the existence of: written service agreements; formal liaison; referral and discharge planning processes; formal and routine consultation; protocols; partnership working groups; memoranda of understanding with other providers; and case conferencing.

Where partnerships exist for case conferencing purposes, record all partners involved.

CODE 1 Palliative care services

Includes services whose substantive work is with patients who have a life-limiting illness. These palliative care services may provide services in the community and/or in admitted patient settings (including hospices).

CODE 2 Hospitals

Includes emergency departments. Excludes hospices/designated palliative care units in a hospital, and other palliative care agencies as defined under Code 1. Also excludes hospital-based allied health services and individual medical practitioners.

CODE 7 Medical practices

Includes practices of general practitioners and individual specialist physicians such as specialists in palliative care, oncologists, urologists and neurologists.

CODE 8 Integrated health centres

Includes multipurpose centres, aged care centres and specialist care centres such as cancer centres.

CODE 9 Universities/research centres

Includes universities that may undertake research and development projects.

CODE 99 Other

Includes organisations based in the community such as schools, clubs, workplaces, organisations that provide respite care or pastoral care and 'Meals on wheels'.

Collection methods: More than one code can be recorded.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications: Palliative care performance indicators DSS Health, Standard 05/12/2007

Conditional obligation:
Recorded when the data element *Service provider organisation – working partnerships indicator, yes/no code N* is 'yes' (code 1).

Patient days

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of patient days, total N[N(7)]
METeOR identifier:	270045
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of days for all patients who were admitted for an episode of care and who separated during a specified reference period.
Data Element Concept:	Establishment—number of patient days

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N(7)]
Maximum character length:	8
Unit of measure:	Day

Data element attributes

Collection and usage attributes

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).

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.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Is formed using Episode of admitted patient care (newborn) — number of qualified days, total N[NNNN] Health, Standard 01/03/2005

Supersedes Patient days, version 3, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.2 KB)

Patient listing status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—patient listing status, readiness for care code N
METeOR identifier:	269996
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the person's readiness to begin the process leading directly to being admitted to hospital for the awaited procedure, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode—patient listing status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Ready for care
2	Not ready for care

Data element attributes

Collection and usage attributes

Guide for use:

A patient may be 'ready for care' or 'not ready for care'. 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 removal)' and 'Waiting time (at a census date)'.

Comments:

Only patients ready for care are to be included in the National Minimum Data Set - Elective surgery 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 (metadata item Category reassignment date).

At the Waiting Times Working Group meeting on 9 September 1996, it was agreed to separate the metadata items Patient listing status, readiness for care and Clinical urgency as the combination of these items had led to confusion.

Source and reference attributes

Submitting organisation:

Hospital Access Program Waiting Lists Working Group

Waiting Times Working Group

Origin:

National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Patient listing status, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.7 KB)

Is used in the formation of Elective surgery waiting list episode — waiting time (at a census date), total days N[NNN] Health, Standard 01/03/2005

Patient present status (non-admitted patient)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient service event—patient present status, code N
METeOR identifier:	270081
Registration status:	Health, Standard 01/03/2005
Definition:	The presence or absence of a patient at a service event, as represented by a code.
Data Element Concept:	Non-admitted patient service event—patient present status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Patient present with or without carer(s)/relative(s)
2	Carer(s)/relative(s) of the patient only

Data element attributes

Collection and usage attributes

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.

Relational attributes

Related metadata references: Supersedes Non-admitted patient service event - patient present status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB)

Patients in residence at year end

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—patients/clients in residence at year end, total N[NNN]
METeOR identifier:	270046
Registration status:	Health, Standard 01/03/2005
Definition:	A headcount of all formally admitted patients/clients in residence in long-stay facilities.
Data Element Concept:	Establishment—patients/clients in residence at year end

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4
Unit of measure:	Person

Data element attributes

Collection and usage attributes

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 Ageing is able to carry out a statistical census from its residential aged care service databases. 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.
Comments:	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.

Source and reference attributes

Submitting organisation: Morbidity working party

Relational attributes

Related metadata references: Supersedes Patients in residence at year end, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.9 KB)

Percutaneous coronary intervention procedure type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—percutaneous coronary intervention procedure type, code N
Synonymous names:	PCI procedure type
METeOR identifier:	359751
Registration status:	Health, Standard 01/10/2008
Definition:	The type of procedure performed during a percutaneous coronary intervention (PCI), as represented by a code.
Data Element Concept:	Person—percutaneous coronary intervention procedure type

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	String	
Format:	N	
Permissible values:	Value	Meaning
	1	Balloon angioplasty only
	2	Bare metal stent implantation
	3	Drug-eluting stent implantation
Supplementary values:	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Balloon angioplasty only

Use this code where only balloon angioplasty has been performed during a percutaneous coronary intervention.

CODE 2 Bare metal stent implantation

Use this code where a bare metal stent has been implanted during a percutaneous coronary intervention.

CODE 3 Drug-eluting stent implantation

Use this code where at least one drug-eluting stent has been implanted during a percutaneous coronary intervention (i.e. if more than one stent has been placed during the procdure and at least one stent is a drug-eluting stent).

CODES 2 and 3 include the performance of balloon angioplasty.

Data element attributes

Source and reference attributes

Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Implementation in Data Set Specifications:

Coronary artery cluster Health, Standard 01/10/2008

Conditional obligation:
Record when a percutaneous coronary intervention is performed. This includes those performed for primary, rescue or revascularisation reasons.

Perineal status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female (mother)—postpartum perineal status, code N
METeOR identifier:	269939
Registration status:	Health, Standard 01/03/2005
Definition:	The state of the perineum following birth, as represented by a code.
Context:	Perinatal
Data Element Concept:	Female (mother)—postpartum perineal status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
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

Supplementary values:

Value	Meaning
9	Not stated

Collection and usage attributes

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.
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.

Data element attributes

Collection and usage attributes

Comments: 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 attributes

Related metadata references: Supersedes Perineal status, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.8 KB)

Period of residence in Australia

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—period of residence in Australia, years code NN
METeOR identifier:	270050
Registration status:	Health, Standard 01/03/2005
Definition:	Length of time in years a person has lived in Australia.
Data Element Concept:	Person—period of residence in Australia

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
00	Under one year residence in Australia
01-97	1 to 97 years residence in Australia
98	Born in Australia

Supplementary values:

99	Unknown

Data element attributes

Collection and usage attributes

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.

Comments: This metadata 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.

This item was not considered a high priority by the Office of Multicultural Affairs (1988) and to date only the 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.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Period of residence in Australia, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.6 KB)

Peripheral neuropathy (status)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—peripheral neuropathy indicator, code N
METeOR identifier:	302457
Registration status:	Health, Standard 21/09/2005
Definition:	Whether peripheral neuropathy is present, as represented by a code.
Data Element Concept:	Person—peripheral neuropathy indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes: Record if peripheral neuropathy is present in the person. CODE 2 No: Record if peripheral neuropathy is not present in the person. Record whether or not peripheral neuropathy is present determined by clinical judgement following assessment using pinprick and vibration (using perhaps a Biothesiometer) or Monofilament.
Collection methods:	Examine for neuropathy by testing reflexes and sensation preferably using tuning fork (standard vibration fork 128 hz), pinprick, 10g monofilament and/or biothesiometer. The preferred assessment methods are monofilament and biothesiometer. These two non-invasive tests provide more objective and repeatable results than testing sensation with pinprick or a tuning fork, which are very difficult to standardise.

1 The 'Touch-Test' Sensory Evaluation (Semmens-Weinstein Monofilaments) application guidelines:

- Occlude the patient's vision by using a shield or by having the patient look away or close his or her eyes.
- Instruct the patient to respond when a stimulus is felt by saying 'touch' or 'yes'.
- Prepare to administer the stimulus to the foot (dorsal or plantar surface).
- Press the filament of the Touch
- Test at a 90 degree angle against the skin until it bows. Hold in place for approximately 1.5 seconds and then remove.

To assure the validity of the sensory test findings:

- The patient must not be able to view the administration of the stimuli so that false indications are avoided.
- The nylon filament must be applied at a 90 degree angle against the skin until it bows for approximately 1.5 second before removing.
- If the patient does not feel the filament, then protective pain sensation has been lost.

2 Testing vibration sensation with a biothesiometer - application guidelines:

- The biothesiometer has readings from 0 to 50 volts. It can be made to vibrate at increasing intensity by turning a dial.
- A probe is applied to part of the foot, usually on the big toe.
- The person being tested indicates as soon as he/she can feel the vibration and the reading on the dial at that point is recorded.

The reading is low in young normal individuals (i.e. they are very sensitive to vibration). In older individuals, the biothesiometer reading becomes progressively higher. From experience, it is known that the risk of developing a neuropathic ulcer is much higher if a person has a biothesiometer reading greater than 30-40 volts.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Reference documents:

1997 North Coast Medical, INC. San Jose, CA 95125; 800 821 - 9319

Duffy MD, John C and Patout MD, Charles A. 1990. 'Management of the Insensitive Foot in Diabetes: Lessons from Hansen's Disease'. Military Medicine, 155:575-579

Bell- Krotovski OTR, FAOT, FAOTA, Judith and Elizabeth Tomancik LOTR. 1987.The Repeatability of testing with Semmens-Weinstein Monofilaments. 'The Journal of Hand Surgery,' 12A: 155 - 161

Edmonds M, Boulton A, Buckenham T, et al. Report of the Diabetic Foot and Amputation Group. Diabet Med 1996; 13: S27 - 42

Foot Examination -an interactive guide; Aust Prescr 2002; 25:8 - 10

Relational attributes

Related metadata references: Supersedes Person—peripheral neuropathy status, code N Health, Superseded 21/09/2005

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Standard 21/09/2005

Peripheral vascular disease in feet (status)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—peripheral vascular disease indicator (foot), code N
METeOR identifier:	302459
Registration status:	Health, Standard 21/09/2005
Definition:	Whether peripheral vascular disease is present in either foot, as represented by a code.
Data Element Concept:	Person—peripheral vascular disease indicator (foot)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 9 Not stated/inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use: CODE 1 Yes: Record if peripheral vascular disease is present in either foot.

CODE 2 No: Record if peripheral vascular disease is not present in either foot.

Collection methods: If it is mild, peripheral vascular disease can be completely without symptoms. However, compromised blood supply in the long term could cause claudication (pain in the calf after walking for a distance or up an incline or stairs), rest pain or vascular ulceration.

Physical examination is necessary to assess the peripheral vascular circulation. Purplish colour and cold temperature of feet are indications to suspect that the circulation may be impaired.

Palpate pulses:

The simplest method to estimate blood flow and to detect

ischaemia to the lower extremities is palpation of the foot pulses (posterior tibial and dorsalis pedis arteries) in both feet. Note whether pulses are present or absent. If pulses in the foot can be clearly felt, the risk of foot ulceration due to vascular disease is small.

Test capillary return:

A helpful confirmation sign of arterial insufficiency is pallor of the involved feet after 1 - 2 min of elevation if venous filling time is delayed beyond the normal limit of 15 sec.

Doppler probe:

If pulses cannot be palpated, apply a small hand-held Doppler, placed over the dorsalis pedis or posterior tibial arteries to detect pulses, quantify the vascular supply and listen to the quality of the signal.

When the foot pulses are very weak or not palpable, the risk assessment could be completed by measuring the ankle brachial index (ankle pressure/ brachial pressure). Normal ankle brachial index is 0.9 - 1.2. An ankle brachial index less than 0.6 indicates compromised peripheral circulation.

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:	Supersedes Person—peripheral vascular disease status (foot), code N Health, Superseded 21/09/2005
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Standard 21/09/2005

Person identifier

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—person identifier, XXXXXX[X(14)]
METeOR identifier:	290046
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005
Definition:	Person identifier unique within an establishment or agency.
Data Element Concept:	Person—person identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	XXXXXX[X(14)]
Maximum character length:	20

Data element attributes

Collection and usage attributes

Guide for use:	Individual agencies, establishments or collection authorities may use their own alphabetic, numeric or alphanumeric coding systems. Field cannot be blank.

Source and reference attributes

Reference documents:	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references:	Supersedes Person—person identifier (within establishment/agency), XXXXXX[X(14)] Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008 Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008 Admitted patient care NMDS Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Admitted patient palliative care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient palliative care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient palliative care NMDS 2007-08 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient palliative care NMDS 2008-09 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient palliative care NMDS 2009-10 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient palliative care NMDS 2010-11 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Alcohol and other drug treatment services NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Superseded 06/03/2009

Cancer (clinical) DSS Health, Superseded 22/12/2009

Cancer (clinical) DSS Health, Standard 22/12/2009

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Community mental health care 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Community mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Community mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Community mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Community mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Health care client identification DSS Health, Superseded 03/12/2008

Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Superseded 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Non-admitted patient emergency department care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Perinatal NMDS Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Perinatal NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Perinatal NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Residential mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Residential mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Person identifier type—health care (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (identifier)—identifier type, geographic/administrative scope code A
METeOR identifier:	270053
Registration status:	Health, Standard 01/03/2005
Definition:	A code based on the geographical or administrative breadth of applicability of Person identifier.
Data Element Concept:	Person (identifier)—identifier type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A
Maximum character length:	1

Permissible values:

Value	Meaning
L	Local
A	Area/region/district
S	State or territory

Collection and usage attributes

Guide for use:

CODE L Local

This code is for an identifier that is applicable only inside the issuing health care establishment

CODE A Area/region/district

This code is for an identifier that is applicable to:

- all the area/region/district health care services but not across all services in the state or territory; or
- all of a specific health care service (e.g. community mental health) in an area/region/district health care services but not across all those services in the state or territory

CODE S State or territory

This code is for identifiers that are applicable across all state or territory health care services.

Data element attributes

Collection and usage attributes

Guide for use:

A person can have more than one person identifier. Each Person identifier must have an appropriate person identifier type code recorded.

Use this field to record only identifier type. It must not be used to record any other person related information.

Source and reference attributes

Submitting organisation: Standards Australia

Origin: AS5017 Health Care Client Identification

Relational attributes

Related metadata references: Supersedes Person identifier type - health care, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Implementation in Data Set Specifications:

Health care client identification Health, Superseded 04/05/2005

Health care client identification DSS Health, Superseded 03/12/2008

Health care client identification DSS Health, Standard 03/12/2008

Pharmacotherapy type prescribed for acute coronary syndrome in hospital

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with acute coronary syndrome—pharmacotherapy type prescribed in hospital, code N[N]
Synonymous names:	ACS pharmacotherapy type prescribed
METeOR identifier:	344344
Registration status:	Health, Standard 01/10/2008
Definition:	The type of pharmacotherapy prescribed to a person in hospital for the treatment of acute coronary syndrome, as represented by a code.
Data Element Concept:	Person with acute coronary syndrome—pharmacotherapy type prescribed in hospital

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	Aspirin
2	Angiotensin converting enzyme (ACE) inhibitor
3	Angiotensin II receptor blocker
4	Antithrombin
5	Beta-blocker
6	Clopidogrel
7	Fibrinolytic
8	Glycoprotein IIb/IIIa receptor antagonist
9	Statin

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Aspirin

Includes: aspirin, astrix, cardiprin, cartia, aspro, disprin and solprin

CODE 2 Angiotensin converting enzyme (ACE) inhibitor

Includes: captopril, enalapril, fosinopril, lisinopril, perindopril, quinapril, ramipril and trandolapril

CODE 3 Angiotensin II receptor blocker

Includes: candesartan, eprosartan, irbesartan, losartin and temisartan

CODE 4 Antithrombin

Includes: dalteparin, danaparoid, enoxaparin, heparin, phenindione, warfarin, bivalirudin, fondaparinux, lepirudin

CODE 5 Beta-blocker

Includes: atenolol, bisoprolol, carvedilol, esmolol, labetolol, metoprolol, oxprenolol, pindolol, propranolol and sotalol

CODE 6 Clopidogrel

Includes: iscover and plavix

CODE 7 Fibrinolytic

Includes: streptokinase, tissue plasminogen activator (t-PA) (alteplase), reteplase (r-PA) and tenecteplase (TNK t-PA)

CODE 8 Glycoprotein IIb/IIIa receptor

Includes: abciximab, eptifibatide and tirofiban

CODE 9 Statin

Includes: atorvastatin, fluvastatin, pravastatin and simvastatin

Data element attributes

Collection and usage attributes

Guide for use: A person may be prescribed one or more type of medication for acute coronary syndromes. Therefore more than one code may be recorded.

Collection methods: This information should be recorded at the end of the person's hospital stay involving the treatment of acute coronary syndromes.

Comments: The purpose of this data element is to collect information on the prescription of pharmacotherapy recommended for the treatment of acute coronary syndromes in the national guidelines. Additional information on the specific drug types prescribed is not required for this quality purpose.

The health service may choose to collect additional information on the specific drug types prescribed within each of the core pharmacotherapies.

Source and reference attributes

Reference documents: National Heart Foundation of Australia & Cardiac Society of Australia and New Zealand. Guidelines for the management of acute coronary syndromes 2006. Med J Aust 2006; 184; S1-S32. © MJA 2006

Relational attributes

Implementation in Data Set Specifications: Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008

Pharmacotherapy type taken for acute coronary syndrome post discharge

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with acute coronary syndrome—pharmacotherapy type taken post discharge from hospital, code N[N]
METeOR identifier:	344822
Registration status:	Health, Standard 01/10/2008
Definition:	The type of pharmacotherapy being taken by a person for the treatment of acute coronary syndrome following discharge from hospital, as represented by a code.
Data Element Concept:	Person with acute coronary syndrome—pharmacotherapy type taken post discharge from hospital

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	Aspirin
2	Angiotensin converting enzyme (ACE) inhibitor
3	Angiotensin II receptor blocker
4	Beta-blocker
5	Clopidogrel
6	Statin

Supplementary values:

99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Aspirin

Includes: aspirin, astrix, cardiprin, cartia, aspro, disprin and solprin

CODE 2 Angiotensin converting enzyme (ACE) inhibitor

Includes: captopril, enalapril, fosinopril, lisinopril, perindopril, quinapril, ramipril and trandolapril

CODE 3 Angiotensin II receptor blocker

Includes: candesartan, eprosartan, irbesartan, losartin and temisartan

CODE 4 Beta-blocker

Includes: atenolol, bisoprolol, carvedilol, esmolol, labetolol, metoprolol, oxprenolol, pindolol, propranolol and sotalol

CODE 5 Clopidogrel

Includes: iscover and plavix

CODE 6 Statin

Includes: atorvastatin, fluvastatin, pravastatin and simvastatin

Data element attributes

Collection and usage attributes

Guide for use:	A person may be taking one or more type of medication for acute coronary syndromes (ACS). Therefore more than one code may be recorded.
Collection methods:	Following a person's hospital stay for ACS, follow-up consultations with a clinician may occur at various intervals, such as 3, 6 or 12 months after discharge from hospital. The medications being taken by the person at the time of each follow-up consultation should be recorded.
Comments:	The pharmacotherapies for the treatment of ACS that could be taken post discharge from hospital are different from the types that could be taken during the hospital stay as not all of the pharmacotherapies used for the treatment of ACS are for out of hospital use.

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008

Physical activity sufficiency status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—physical activity sufficiency status, code N
METeOR identifier:	270054
Registration status:	Health, Standard 01/03/2005
Definition:	Sufficiency of moderate or vigorous physical activity to confer a health benefit, as represented by a code.
Data Element Concept:	Person—physical activity sufficiency status

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Sufficient
	2	Insufficient
	3	Sedentary
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

The clinician makes a judgment based on assessment of the person's reported physical activity history for a usual 7-day period where:

CODE 1:

Sufficient physical activity for health benefit for a usual 7-day period is calculated by summing the total minutes of walking, moderate and/or vigorous physical activity.

Vigorous physical activity is weighted by a factor of two to account for its greater intensity. Total minutes for health benefit need to be equal to or more than 150 minutes per week.

CODE 2:

Insufficient physical activity for health benefit is where the sum of the total minutes of walking, moderate and/or vigorous physical activity for a usual 7-day period is less than 150 minutes but more than 0 minutes.

CODE 3:

Sedentary is where there has been no moderate and/or vigorous physical activity during a usual 7-day period.

CODE 9:

There is insufficient information to more accurately define the person's physical activity sufficiency status or the information is not known.

Note: The National Heart Foundation of Australia and the National Physical Activity Guidelines for Australians describes moderate-intensity physical activity as causing a slight but noticeable, increase in breathing and heart rate and suggests that the person should be able to comfortably talk but not sing. Examples of moderate physical activity include brisk walking, low pace swimming, light to moderate intensity exercise classes. Vigorous physical activity is described as activity, which causes the person to 'huff and puff', and where talking in a full sentence between breaths is difficult.

Examples of vigorous physical activity include jogging, swimming (freestyle) and singles tennis.

Comments:

The above grouping subdivides a population into three mutually exclusive categories.

A sufficiently physically active person is a person who is physically active on a regular weekly basis equal to or in excess of that required for a health benefit. Sufficient physical activity for health results from participation in physical activity of adequate duration and intensity. Although there is no clear absolute threshold for health benefit, the accrual of 150 minutes of moderate (at least) intensity physical activity over a period of one week is thought to confer health benefit. Walking is included as a moderate intensity physical activity. Note that the 150 minutes of moderate physical activity should be made up of 30 minutes on most days of the week and this can be accumulated in 10 minute bouts (National Physical Activity Guidelines for Australians).

Health benefits can also be obtained by participation in vigorous physical activity, in approximate proportion to the total amount of activity performed, measured either as energy expenditure or minutes of physical activity (Pate et al. 1995).

Physical activity - health benefit for vigorous physical activity is calculated by:

- incorporating a weighted factor of 2, to account for its greater intensity
- summing the total minutes of walking, moderate and/or vigorous physical activity will then give an indication if a health benefit is likely.

Insufficient physical activity describes a person who engages in regular weekly physical activity but not to the level required for a health benefit through either moderate or vigorous physical activity.

A sedentary person is a person who does not engage in any regular weekly physical activity.

Source and reference attributes

Submitting organisation:	Cardiovascular Data Working Group
Origin:	The National Heart Foundation of Australia's Physical Activity Policy, April 2001. National Physical Activity Guidelines For Australians, developed by the University of Western Australia & the Centre for Health Promotion

Relational attributes

Related metadata references:	Supersedes Physical activity sufficiency status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.5 KB)
Implementation in Data Set Specifications:	Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006 Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007 Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009 Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Place of occurrence of external cause of injury (ICD-10-AM)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—place of occurrence, code (ICD-10-AM 7th edn) ANN{.N[N]}
METeOR identifier:	391334
Registration status:	Health, Standard 22/12/2009
Definition:	The place where the external cause of injury, poisoning or adverse effect occurred, as represented by a code.
Data Element Concept:	Injury event—place of occurrence

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:	Admitted patient: External cause codes in the range V00 to Y89 must be accompanied by a place of occurrence code. External cause codes V00 to Y34 must be accompanied by an activity code.
Comments:	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.

Source and reference attributes

Origin:	National Centre for Classification in Health AIHW National Injury Surveillance Unit National Data Standards for Injury Surveillance Advisory Group

Relational attributes

Related metadata references:	Supersedes Injury event—place of occurrence, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009
Implementation in Data Set	Admitted patient care NMDS 2010-2011 Health, Standard

Specifications:	22/12/2009
	Implementation start date: 01/07/2010
	Injury surveillance DSS Health, Standard 14/12/2009

Place of occurrence of external cause of injury (non-admitted patient)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—place of occurrence, non-admitted patient code N[N]
METeOR identifier:	268949
Registration status:	Health, Standard 01/03/2005
Definition:	The place where the external cause of injury, poisoning or adverse effect occurred, as represented by a code.
Data Element Concept:	Injury event—place of occurrence

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
0	Home
1	Residential Institution
2	School, other institution and public administration 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

Supplementary values:

Value	Meaning
9	Unspecified place

Data element attributes

Collection and usage attributes

Guide for use:	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.

Source and reference attributes

Origin:

National Centre for Classification in Health

AIHW National Injury Surveillance Unit

National Data Standards for Injury Surveillance Advisory Group

National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Place of occurrence of external cause of injury, version 6, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.1 KB)

Implementation in Data Set Specifications:

Injury surveillance DSS Health, Superseded 05/02/2008

Injury surveillance DSS Health, Superseded 14/12/2009

Injury surveillance DSS Health, Standard 14/12/2009

Injury surveillance NMDS Health, Superseded 03/05/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Injury surveillance NMDS Health, Superseded 07/12/2005

Postal delivery point identifier (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—postal delivery point identifier, {N(8)}
Synonymous names:	Australian delivery point identifier
METeOR identifier:	287220
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005
Definition:	A unique number assigned to a person's postal address as recorded on the Australia Post Postal Address File (PAF).
Data Element Concept:	Person (address)—postal delivery point identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	Number
Format:	{N(8)}
Maximum character length:	8

Source and reference attributes

Origin:	Customer Barcoding Technical Specifications, 1998: Australia Post
Reference documents:	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Data element attributes

Collection and usage attributes

Guide for use:	Australia Post maintains a Postal Address File (PAF) database which contains Australian postal delivery addresses and their corresponding eight (8) character unique identification number known as a Delivery Point Identifier (DPID). While the PAF is concerned with postal address, for many persons' a postal address will be the same as their residential address. The PAF can be used to improve the recording of address data at the time of data collection. The Postal Address File may be used at the time of data collection to confirm that the combined metadata items of address line, suburb/town/locality, Australian state/territory identifier and postcode - Australian are accurately recorded.
Collection methods:	The Delivery Point Identifier (DPID) is assigned electronically to recognised Australia Post delivery addresses following reference to the Postal Address File (PAF) database.

Comments:

In October 1999, Australia Post introduced a bar-coding system for bulk mail lodgements. Agencies or establishments can use software to improve the quality of person address data it collects and records and, at the same time, receive financial benefits by reducing its postage expenses.

The DPID is easily converted to a bar code and can be included on correspondence and address labels. If the bar code is displayed on a standard envelope that passes through a mail-franking machine (e.g. as used by most major hospitals), the postage cost is reduced. Every three months, Australia Post provides updates to the PAF database. For more information, contact Australia Post.

Source and reference attributes

Submitting organisation:

Standards Australia

Origin:

National Health Data Standards Committee

National Community Services Data Committee

Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Reference documents:

AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

Related metadata references:

Supersedes Person (address)—postal delivery point identifier, {N(8)} Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005

Is formed using Person (address)—suburb/town/locality name, text [A(50)] Health, Standard 04/05/2005, Community services, Standard 25/08/2005

Implementation in Data Set Specifications:

Health care client identification DSS Health, Superseded 03/12/2008

Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Superseded 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Postal delivery point identifier (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—postal delivery point identifier, {N(8)}
METeOR identifier:	290141
Registration status:	Health, Standard 04/05/2005 Community services, Standard 31/08/2005
Definition:	A unique number assigned to a service provider organisation's postal address as recorded on the Australia Post Postal Address File (PAF).
Data Element Concept:	Service provider organisation (address)—postal delivery point identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	Number
Format:	{N(8)}
Maximum character length:	8

Source and reference attributes

Origin:	Customer Barcoding Technical Specifications, 1998: Australia Post
Reference documents:	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Data element attributes

Collection and usage attributes

Collection methods:	The Delivery Point Identifier (DPID) is assigned electronically to recognised Australia Post delivery addresses following reference to the Postal Address File (PAF) database.
Comments:	In October 1999, Australia Post introduced a bar-coding system for bulk mail lodgements. Agencies or establishments can use software to improve the quality of person address data it collects and records and, at the same time, receive financial benefits by reducing its postage expenses. The DPID is easily converted to a bar code and can be included on correspondence and address labels. If the bar code is displayed on a standard envelope that passes through a mail-

franking machine (e.g. as used by most major hospitals), the postage cost is reduced. Every three months, Australia Post provides updates to the PAF database. For more information, contact Australia Post.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	National Health Data Standards Committee
	National Community Services Data Committee
	Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Relational attributes

Related metadata references:	Is formed using Service provider organisation (address) — suburb/town/locality name, text [A(50)] Health, Standard 04/05/2005, Community services, Standard 31/08/2005
Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007
	Health care provider identification DSS Health, Superseded 03/12/2008
	Health care provider identification DSS Health, Standard 03/12/2008

Postal delivery service number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—postal delivery service type identifier, [X(11)]
METeOR identifier:	270032
Registration status:	Health, Standard 01/03/2005
Definition:	An identifier for the postal delivery service where a person is located.
Data Element Concept:	Person (address)—postal delivery service type identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	[X(11)]
Maximum character length:	11

Data element attributes

Collection and usage attributes

Guide for use:	The identification of a postal delivery service may be composed of a prefix, a number, and a suffix as per the following format: Prefix A(3) Number N(5) Suffix A(3) May optionally include a prefix and suffix which are non-numeric. The identification may also not be required for certain services. Examples: PO BOX C96 CARE PO RMB 123 GPO BOX 1777Q
Collection methods:	To be collected in conjunction with Postal delivery service type - abbreviation.

Source and reference attributes

Origin:	Health Data Standards Committee AS4590 Interchange of client information

Relational attributes

Related metadata references:	Supersedes Postal delivery service number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.3 KB)

Postal delivery service type—abbreviation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—postal delivery service type, code AA[A(9)]
METeOR identifier:	270027
Registration status:	Health, Standard 01/03/2005
Definition:	Type of postal delivery service for a person, as represented by a code.
Data Element Concept:	Person—postal delivery service type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	AA[A(9)]
Maximum character length:	11

Permissible values:

Value	Meaning
CARE PO	Care-of Post Office (also known as Poste Restante)
CMA	Community Mail Agent
CMB	Community Mail Bag
GPO BOX	General Post Office Box
LOCKED BAG	Locked Mail Bag Service
MS	Mail Service
PO BOX	Post Office Box
PRIVATE BAG	Private Mail Bag Service
RSD	Roadside Delivery
RMB	Roadside Mail Box/Bag
RMS	Roadside Mail Service

Collection and usage attributes

Collection methods:	To be collected in conjunction with Person (address)—postal delivery service type identifier, [X(11)] when applicable.

Source and reference attributes

Origin:	AS4590 Interchange of client information

Data element attributes

Source and reference attributes

Origin: Health Data Standards Committee

Relational attributes

Related metadata references: Supersedes Postal delivery service type - abbreviation, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.5 KB)

Postcode—Australian (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—Australian postcode, code (Postcode datafile) {NNNN}
Synonymous names:	Australian postcode
METeOR identifier:	287224
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 10/02/2006
Definition:	The numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of a person.
Data Element Concept:	Person (address)—Australian postcode

Value domain attributes

Representational attributes

Classification scheme:	Postcode datafile
Representation class:	Code
Data type:	Number
Format:	{NNNN}
Maximum character length:	4

Collection and usage attributes

Comments:	Postcode - Australian may be used in the analysis of data on a geographical basis, which involves a conversion from postcodes to the Australian Bureau of Statistics (ABS) postal areas. This conversion results in some inaccuracy of information. However, in some data sets postcode is the only geographic identifier, therefore the use of other more accurate indicators (e.g. Statistical Local Area (SLA)) is not always possible. When dealing with aggregate data, postal areas, converted from postcodes, can be mapped to Australian Standard Geographical Classification codes using an ABS concordance, for example to determine SLAs. It should be noted that such concordances should not be used to determine the SLA of any individual's postcode. Where individual street addresses are available, these can be mapped to ASGC codes (e.g. SLAs).

Data element attributes

Collection and usage attributes

Guide for use:	The postcode book is updated more than once annually; as postcodes are a dynamic entity and are constantly changing.
Collection methods:	Leave Postcode - Australian blank for:

- Any overseas address
- Unknown address
- No fixed address.

May be collected as part of Address line or separately. Postal addresses may be different from where a person actually resides.

Source and reference attributes

Submitting organisation: Standards Australia

Origin: National Health Data Committee

National Community Services Data Committee

Reference documents: AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia

AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Australia Post Postcode book. Reference through:

http://www1.auspost.com.au/postcodes/

Relational attributes

Related metadata references: See also Person—Australian state/territory identifier, code N Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 10/02/2006

Supersedes Person (address)—Australian postcode (Postcode datafile), code NNN[N] Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005

Is used in the formation of Person—geographic location, community services code (ASGC 2004) NNNNN Community services, Superseded 02/05/2006

Is used in the formation of Dwelling—geographic location, remoteness structure code (ASGC 2004) N[N] Housing assistance, Retired 10/02/2006

Implementation in Data Set Specifications: Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Computer Assisted Telephone Interview demographic module DSS Health, Superseded 03/12/2008

Computer Assisted Telephone Interview demographic module DSS Health, Standard 03/12/2008

Health care client identification DSS Health, Superseded 03/12/2008

Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Superseded 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Registered chiropractic labour force DSS Health, Standard 10/12/2009

Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009

Registered medical professional labour force DSS Health, Standard 10/12/2009

Registered midwifery labour force DSS Health, Standard 10/12/2009

Registered nursing professional labour force DSS Health, Standard 10/12/2009

Registered optometry labour force DSS Health, Standard 10/12/2009

Registered osteopathy labour force DSS Health, Standard 10/12/2009

Registered pharmacy labour force DSS Health, Standard 10/12/2009

Registered physiotherapy labour force DSS Health, Standard 10/12/2009

Registered podiatry labour force DSS Health, Standard 10/12/2009

Registered psychology labour force DSS Health, Standard 10/12/2009

Postcode—Australian (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—Australian postcode, code (Postcode datafile) {NNNN}
METeOR identifier:	290064
Registration status:	Health, Standard 04/05/2005 Community services, Standard 31/08/2005
Definition:	The numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of an organisation, as represented by a code.
Data Element Concept:	Service provider organisation (address)—Australian postcode

Value domain attributes

Representational attributes

Classification scheme:	Postcode datafile
Representation class:	Code
Data type:	Number
Format:	{NNNN}
Maximum character length:	4

Collection and usage attributes

Comments:

Postcode - Australian may be used in the analysis of data on a geographical basis, which involves a conversion from postcodes to the Australian Bureau of Statistics (ABS) postal areas. This conversion results in some inaccuracy of information. However, in some data sets postcode is the only geographic identifier, therefore the use of other more accurate indicators (e.g. Statistical Local Area (SLA)) is not always possible.

When dealing with aggregate data, postal areas, converted from postcodes, can be mapped to Australian Standard Geographical Classification codes using an ABS concordance, for example to determine SLAs. It should be noted that such concordances should not be used to determine the SLA of any individual's postcode. Where individual street addresses are available, these can be mapped to ASGC codes (e.g. SLAs).

Data element attributes

Collection and usage attributes

Collection methods:

May be collected as part of Address line or separately. Postal addresses may be different from where a service is actually located.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	National Health Data Committee
	National Community Services Data Committee
	Australia Post Postcode book. Reference through:
	http://www1.auspost.com.au/postcodes/
Reference documents:	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia
	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007
	Health care provider identification DSS Health, Superseded 03/12/2008
	Health care provider identification DSS Health, Standard 03/12/2008

Postcode—Australian (workplace)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Workplace (address)—Australian postcode, code (Postcode datafile) {NNNN}
METeOR identifier:	386199
Registration status:	Health, Standard 10/12/2009
Definition:	The numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of a workplace, as represented by a code.
Data Element Concept:	Workplace (address)—Australian postcode

Value domain attributes

Representational attributes

Classification scheme:	Postcode datafile
Representation class:	Code
Data type:	Number
Format:	{NNNN}
Maximum character length:	4

Collection and usage attributes

Comments:

Postcode - Australian may be used in the analysis of data on a geographical basis, which involves a conversion from postcodes to the Australian Bureau of Statistics (ABS) postal areas. This conversion results in some inaccuracy of information. However, in some data sets postcode is the only geographic identifier, therefore the use of other more accurate indicators (e.g. Statistical Local Area (SLA)) is not always possible.

When dealing with aggregate data, postal areas, converted from postcodes, can be mapped to Australian Standard Geographical Classification codes using an ABS concordance, for example to determine SLAs. It should be noted that such concordances should not be used to determine the SLA of any individual's postcode. Where individual street addresses are available, these can be mapped to ASGC codes (e.g. SLAs).

Data element attributes

Collection and usage attributes

Collection methods:

May be collected as part of Address line or separately. Postal addresses may be different from where a workplace is actually located.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

Main job of registered chiropractor cluster Health, Standard 10/12/2009

Main job of registered dental and allied dental health professional cluster Health, Standard 10/12/2009

Main job of registered medical professional cluster Health, Standard 10/12/2009

Main job of registered midwife cluster Health, Standard 10/12/2009

Main job of registered nursing professional cluster Health, Standard 10/12/2009

Main job of registered optometrist cluster Health, Standard 10/12/2009

Main job of registered osteopath cluster Health, Standard 10/12/2009

Main job of registered pharmacist cluster Health, Standard 10/12/2009

Main job of registered physiotherapist cluster Health, Standard 10/12/2009

Main job of registered podiatrist cluster Health, Standard 10/12/2009

Main job of registered psychologist cluster Health, Standard 10/12/2009

Second job of registered chiropractor cluster Health, Standard 10/12/2009

Second job of registered dental and allied dental health professional cluster Health, Standard 10/12/2009

Second job of registered medical professional cluster Health, Standard 10/12/2009

Second job of registered midwife cluster Health, Standard 10/12/2009

Second job of registered nursing professional cluster Health, Standard 10/12/2009

Second job of registered optometrist cluster Health, Standard 10/12/2009

Second job of registered osteopath cluster Health, Standard 10/12/2009

Second job of registered pharmacist cluster Health, Standard 10/12/2009

Second job of registered physiotherapist cluster Health, Standard 10/12/2009

Second job of registered podiatrist cluster Health, Standard 10/12/2009

Second job of registered psychologist cluster Health, Standard 10/12/2009

Postcode—international (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—international postcode, text [X(10)]
Synonymous names:	International postcode
METeOR identifier:	288985
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The code for a postal delivery area, aligned with locality, suburb or place for the address of a person, as defined by the postal service of a country other than Australia, as represented by text.
Data Element Concept:	Person (address)—international postcode

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(10)]
Maximum character length:	10

Data element attributes

Collection and usage attributes

Collection methods:	This is a self-reported code from a person and may be non-verifiable without reference to the specific country's coding rules. May be collected as part of Address or separately. Postal addresses may be different from where a person actually resides.

Source and reference attributes

Submitting organisation:	Standards Australia
Reference documents:	AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

Implementation in Data Set Specifications:	Health care client identification DSS Health, Superseded 03/12/2008 Health care client identification DSS Health, Standard 03/12/2008 Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Superseded 03/12/2008 Health care provider identification DSS Health, Standard 03/12/2008

Postcode—international (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—international postcode, text [X(10)]
METeOR identifier:	288987
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The code for a postal delivery area, aligned with locality, suburb or place for the address of an organisation, as defined by the postal service of a country other than Australia.
Data Element Concept:	Service provider organisation (address)—international postcode

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(10)]
Maximum character length:	10

Data element attributes

Collection and usage attributes

Collection methods:	This is a self-reported code from an organisation and may be non-verifiable without reference to the specific country's coding rules. May be collected as part of Address or separately. Postal addresses may be different from where a service is actually located.

Source and reference attributes

Submitting organisation:	Standards Australia

Relational attributes

Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Superseded 03/12/2008 Health care provider identification DSS Health, Standard 03/12/2008

Postpartum complication

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—complication (postpartum), code (ICD-10-AM 7th edn) ANN{.N[N]}
METeOR identifier:	391336
Registration status:	Health, Standard 22/12/2009
Definition:	Medical and obstetric complications of the mother occurring during the postnatal period up to the time of separation from care, as represented by a code.
Data Element Concept:	Birth event—complication (postpartum)

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Collection and usage attributes

Guide for use:	Complications and conditions should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM.

Data element attributes

Collection and usage attributes

Guide for use:	There is no arbitrary limit on the number of conditions specified.
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. 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.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Origin:	International Classification of Diseases - 10th Revision, Australian Modification (7th Edition 2010) National Centre for Classification in Health, Sydney.

Relational attributes

Related metadata references:	Supersedes Birth event—complication (postpartum), code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009

Preferred language

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—preferred language, code (ASCL 2005) NN{NN}
METeOR identifier:	304128
Registration status:	Health, Standard 08/02/2006 Community services, Standard 29/04/2006
Definition:	The language (including sign language) most preferred by the person for communication, as represented by a code.
Data Element Concept:	Person—preferred language

Value domain attributes

Representational attributes

Classification scheme:	Australian Standard Classification of Languages 2005
Representation class:	Code
Data type:	Number
Format:	NN{NN}
Maximum character length:	4

Collection and usage attributes

Guide for use:

The Australian Standard Classification of Languages (ASCL) has a three- level hierarchical structure. The most detailed level of the classification consists of base units (languages) which are represented by four-digit codes. The second level of the classification comprises narrow groups of languages (the Narrow Group level), identified by the first two digits. The most general level of the classification consists of broad groups of languages (the Broad Group level) and is identified by the first digit. The classification includes Australian Indigenous languages and sign languages.

For example, the Lithuanian language has a code of 3102. In this case 3 denote that it is an Eastern European language, while 31 denote that it is a Baltic language. The Pintupi Aboriginal language is coded as 8713. In this case 8 denote that it is an Australian Indigenous language and 87 denote that the language is Western Desert language.

Language data may be output at the Broad Group level, Narrow Group level or base level of the classification. If necessary significant Languages within a Narrow Group can be presented separately while the remaining Languages in the Narrow Group are aggregated. The same principle can be adopted to highlight significant Narrow Groups within a Broad Group.

Data element attributes

Collection and usage attributes

Guide for use: This may be a language other than English even where the person can speak fluent English.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: ABS cat. no. 1267.0. Australian Standard Classification of Languages (ASCL), 2005-06. Canberra: Australian Bureau of Statistics

Relational attributes

Related metadata references: See also Person—main language other than English spoken at home, code (ASCL 2005) NN{NN} Health, Standard 08/02/2006, Community services, Standard 29/04/2006, Housing assistance, Standard 10/02/2006

Supersedes Person—preferred language, code NN Health, Superseded 08/02/2006

Implementation in Data Set Specifications: Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Alcohol and other drug treatment services NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Pregnancy duration at the first antenatal care visit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Pregnancy—estimated duration (at the first visit for antenatal care), completed weeks N[N]
Synonymous names:	Estimated pregnancy gestation in completed weeks at the first visit for antenatal care.
METeOR identifier:	379597
Registration status:	Health, Standard 02/12/2009
Definition:	The total number of completed weeks of a pregnancy's estimated duration on the day of the first visit for antenatal care.
Data Element Concept:	Pregnancy—estimated duration

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]
Maximum character length:	2

Supplementary values:

Value	Meaning
99	Not stated/unknown

Unit of measure: Completed weeks

Data element attributes

Collection and usage attributes

Guide for use:

The day of the first visit for antenatal care is the day of the first contact with a midwife, medical practitioner, or other recognised health professional where antenatal care was provided. It does not include a contact if it was to confirm the pregnancy only or those contacts that occurred during the pregnancy that related to other non pregnancy related issues. It does not include a first contact after the onset of labour.

Antenatal care visits are attributed to the pregnant woman. The duration of the pregnancy on that day is the same as the gestational age of the fetus or baby on that day.

Collection methods:

To be collected at any time during the pregnancy or birth episode after the best estimate of gestational age has been determined.

The method of data collection will usually be from health records of pregnancy and/or birth.

The valid range of completed weeks for Pregnancy duration at the first visit for antenatal care is 3-46.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: See also Product of conception—gestational age, completed weeks N[N] Health, Standard 02/12/2009

Implementation in Data Set Specifications: Perinatal NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Pregnancy—current status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female— pregnancy indicator (current), code N
METeOR identifier:	302817
Registration status:	Health, Standard 21/09/2005
Definition:	Whether the female person is currently pregnant, as represented by a code.
Data Element Concept:	Female— pregnancy indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 9 Not stated/inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use: CODE 1 Yes: Record if the female individual currently pregnant.

CODE 2 No: Record if the female individual not currently pregnant.

Collection methods: Ask the individual if she is currently pregnant.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references:	Supersedes Female—current pregnancy status, code N Health, Superseded 21/09/2005
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Standard 21/09/2005

Premature cardiovascular disease family history (status)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—premature cardiovascular disease family history status, code N
METeOR identifier:	359398
Registration status:	Health, Standard 01/10/2008
Definition:	Whether a person has a first degree relative (father, mother or sibling) who has had a vascular event or condition diagnosed before the age of 60 years, as represented by a code.
Data Element Concept:	Person—premature cardiovascular disease family history status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No
3	Family history status not known

Supplementary values:

9	Not recorded

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1: Yes, the person has a first-degree relative under the age of 60 years who has had a vascular disease/condition diagnosed.

CODE 2: No, the person does not have a first-degree relative under the age of 60 years who has had a vascular disease/condition diagnosed.

CODE 3: Family history status not known, the existence of a premature family history for cardiovascular disease cannot be determined.

CODE 9: Not recorded, the information as to the existence of a premature family history for cardiovascular disease has not been recorded.

Source and reference attributes

Submitting organisation:	Cardiovascular Data Working Group

Origin:	Guidelines Subcommittee of the World Health Organization/International Society of Hypertension (WHO-ISH): 1999 WHO-ISH guidelines for management of hypertension. J Hypertension 1999; 17: 151 - 83.

Relational attributes

Related metadata references:	Supersedes Person—premature cardiovascular disease family history status, code N Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008
	Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Presentation at birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—birth presentation, code N
METeOR identifier:	299992
Registration status:	Health, Standard 06/09/2006
Definition:	The presenting part of the fetus at birth, as represented by a code.
Data Element Concept:	Birth event—birth presentation

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Vertex
2	Breech
3	Face
4	Brow
8	Other

Supplementary values:

9	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Data element attributes

Collection and usage attributes

Guide for use:	Compound presentations (where an extremity prolapses simultaneously alongside the presenting part) should be coded to '8 Other'. All other malpresentations, including for example, cord, shoulder or hand, should be coded to '8 Other'.
Collection methods:	In the case of multiple births, presentation should be recorded for each baby born.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:

Supersedes Birth event—birth presentation, code N Health, Superseded 06/09/2006

Implementation in Data Set Specifications:

Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Perinatal NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Previous pregnancies—ectopic

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—number of previous pregnancies (ectopic), total N[N]
METeOR identifier:	269936
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of previous pregnancies of a female resulting in ectopic pregnancy.
Data Element Concept:	Female—number of previous pregnancies

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]
Maximum character length:	2

Supplementary values:

Value	Meaning
99	Not stated

Unit of measure:	Pregnancy

Data element attributes

Collection and usage attributes

Guide for use:

A pregnancy resulting in multiple births should be counted as once 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.

Comments:

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.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Previous pregnancies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)

Previous pregnancies—induced abortion

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—number of previous pregnancies (induced abortion), total NN
METeOR identifier:	269935
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of previous pregnancies of a female resulting in induced abortion (termination of pregnancy before 20 weeks' gestation).
Data Element Concept:	Female—number of previous pregnancies

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]
Maximum character length:	2

Supplementary values:

Value	Meaning
99	Not stated

Unit of measure:	Pregnancy

Data element attributes

Collection and usage attributes

Guide for use:

A pregnancy resulting in multiple births should be counted as once 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.

Comments:

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 induced abortion may increase the risk of some outcomes in subsequent pregnancies.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Previous pregnancies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)

Previous pregnancies—live birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—number of previous pregnancies (live birth), total NN
METeOR identifier:	269931
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of previous pregnancies of a female resulting in **live birth**.
Data Element Concept:	Female—number of previous pregnancies

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	N[N]	
Maximum character length:	2	
Supplementary values:	Value	Meaning
	99	Not stated
Unit of measure:	Pregnancy	

Data element attributes

Collection and usage attributes

Guide for use:

A pregnancy resulting in multiple births should be counted as once 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.

Comments:

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.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Previous pregnancies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)

Previous pregnancies—spontaneous abortion

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—number of previous pregnancies (spontaneous abortion), total NN
METeOR identifier:	269934
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of previous pregnancies of a female resulting in spontaneous abortion (less than 20 weeks' gestational age, or less than 400 g **birthweight** if gestational age is unknown).
Data Element Concept:	Female—number of previous pregnancies

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	N[N]	
Maximum character length:	2	
Supplementary values:	Value	Meaning
	99	Not stated
Unit of measure:	Pregnancy	

Data element attributes

Collection and usage attributes

Guide for use:

A pregnancy resulting in multiple births should be counted as once 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.

Comments:

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 spontaneous abortion identifies the mother as high risk for subsequent pregnancies.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Previous pregnancies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)

Previous pregnancies—stillbirth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—number of previous pregnancies (stillbirth), total N[N]
METeOR identifier:	269933
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of previous pregnancies of a female resulting in stillbirth (- at least 20 weeks' gestational age or 400 g **birthweight**).
Data Element Concept:	Female—number of previous pregnancies

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	N[N]	
Maximum character length:	2	
Supplementary values:	Value	Meaning
	99	Not stated
Unit of measure:	Pregnancy	

Data element attributes

Collection and usage attributes

Guide for use:

A pregnancy resulting in multiple births should be counted as once 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.

Comments:

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 identifies the mother as high risk for subsequent pregnancies.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Previous pregnancies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)

Previous specialised treatment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—previous specialised treatment, code N
METeOR identifier:	270374
Registration status:	Health, Standard 01/03/2005
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, as represented by a code.
Data Element Concept:	Patient—previous specialised treatment

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
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

Supplementary values:

5	Unknown/not stated

Collection and usage attributes

Guide for use:

CODE 1 Patient has no previous admission(s) or service contact(s) for the specialised treatment now being provided

Use this code for admitted patients, whose only prior specialised treatment contact was the service contact that referred the patient for admission.

CODES 2-4 These codes include 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).

CODE 2 Patient has previous hospital admission(s) but no service contact(s) for the specialised treatment now being provided

CODE 3 Patient has previous service contact(s) but no hospital admission(s) for the specialised treatment now being provided

CODE 4 Patient has both previous hospital admission(s) and service contact(s) for the specialised treatment now being provided

Data element attributes

Collection and usage attributes

Comments:

This metadata item was originally developed in the context of mental health institutional care data development (originally metadata item 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 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.

Source and reference attributes

Submitting organisation: National Mental Health Information Strategy Committee

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Previous specialised treatment, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.7 KB)

Implementation in Data Set Specifications:

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health,

Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Admitted patient palliative care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient palliative care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient palliative care NMDS 2007-08 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient palliative care NMDS 2008-09 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient palliative care NMDS 2009-10 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient palliative care NMDS 2010-11 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Primary site of cancer (ICD-10-AM code)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—primary site of cancer, code (ICD-10-AM 7th edn) ANN{.N[N]}
METeOR identifier:	391340
Registration status:	Health, Standard 22/12/2009
Definition:	The site of origin of the tumour, as opposed to the secondary or metastatic sites, as represented by an ICD-10-AM code.
Data Element Concept:	Person with cancer—primary site of cancer

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Collection and usage attributes

Guide for use:	Report the primary site of cancer, if known, for patients who have been diagnosed with a cancer.

Source and reference attributes

Reference documents:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10)

Data element attributes

Collection and usage attributes

Collection methods:	In a hospital setting, primary site of cancer should be recorded on the patient's medical record by the patient's attending clinician or medical practitioner, and coded by the hospital's medical records department. Hospitals use Diagnosis codes from ICD-10-AM (7th edition). Valid codes must start with C or D. In hospital reporting, the diagnosis code for each separate primary site cancer will be reported as a Principal diagnosis or an Additional diagnosis as defined in the current edition of the Australian Coding Standards. In death reporting, the Australian Bureau of Statistics uses ICD-10. Some ICD-10-AM (7th edition) diagnosis codes e.g. mesothelioma

and Kaposi's sarcoma, are based on morphology and not site alone, and include tumours of these types even where the primary site is unknown.

Source and reference attributes

Origin: World Health Organization

Relational attributes

Related metadata references: Supersedes Person with cancer—primary site of cancer, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009

Implementation in Data Set Specifications: Cancer (clinical) DSS Health, Standard 22/12/2009

Primary site of cancer (ICDO-3 code)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—primary site of cancer, code (ICDO-3) ANN{.N[N]}
METeOR identifier:	370039
Registration status:	Health, Standard 06/03/2009
Definition:	The site of origin of the tumour, as opposed to the secondary or metastatic sites, as represented by an ICDO-3 code.
Data Element Concept:	Person with cancer—primary site of cancer

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Diseases for Oncology 3rd edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Collection and usage attributes

Guide for use:

Report the primary site of cancer, if known, for patients who have been diagnosed with a cancer.

In ICDO, primary site is identified using both the Cxx.x code identifying site and the behaviour code to identify whether the site is the primary site. The behaviour code numbers used in ICDO are listed below:

0 Benign

1 Uncertain whether benign or malignant

- borderline malignancy
- low malignant potential

2 Carcinoma in situ

- intraepithelial
- non-infiltrating
- non-invasive

3 Malignant, primary site

6 Malignant, metastatic site

- malignant, secondary site

9 Malignant, uncertain whether primary or metastatic site

Data element attributes

Collection and usage attributes

Guide for use:

For cancer registries, collection of this data item should only be from notification and pathology reports relating to initial diagnosis and not for recurrent or metastatic disease.

If the primary site differs on multiple pathology or other notification reports for the same tumour, use the most specific value.

For multifocal tumours with foci in more than one quadrant, use the quadrant of the largest focus.

Collection methods:

Cancer registries use Site codes from ICDO 3rd edition.

Source and reference attributes

Origin:

World Health Organization

Relational attributes

Related metadata references:

Supersedes Person with cancer—primary site of cancer, code (ICDO-3) ANN{.N[N]} Health, Superseded 06/03/2009

Implementation in Data Set Specifications:

Breast cancer (Cancer registries) DSS Health, Standard 06/03/2009

Cancer (clinical) DSS Health, Superseded 22/12/2009

Cancer (clinical) DSS Health, Standard 22/12/2009

Principal diagnosis

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—principal diagnosis, code (ICD-10-AM 7th edn) ANN{.N[N]}
METeOR identifier:	391326
Registration status:	Health, Standard 22/12/2009
Definition:	The diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care, an episode of residential care or an attendance at the health care establishment, as represented by a code.
Data Element Concept:	Episode of care—principal diagnosis

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Data element attributes

Collection and usage attributes

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.

As a minimum requirement the Principal diagnosis code must be a valid code from the current edition of ICD-10-AM.

For episodes of admitted patient care, some diagnosis codes are too imprecise or inappropriate to be acceptable as a principal diagnosis and will group to an error DRG in the Australian Refined Diagnosis Related Groups.

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 admitted patient care or episode of residential care or attendance at a health care establishment. The principal diagnosis is derived from and must be substantiated by clinical documentation.

Comments: The principal diagnosis is one of the most valuable health data elements. It is used for epidemiological research, casemix studies and planning purposes.

Source and reference attributes

Origin: National Centre for Classification in Health

National Data Standard for Injury Surveillance Advisory Group

Relational attributes

Related metadata references: Supersedes Episode of care—principal diagnosis, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v 6) NN Health, Standard 22/12/2009

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v 6) ANNA Health, Standard 22/12/2009

Implementation in Data Set Specifications: Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Admitted patient mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Admitted patient palliative care NMDS 2010-11 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Community mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Residential mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Principal drug of concern

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—drug of concern (principal), code (ASCDC 2000 extended) NNNN
METeOR identifier:	270109
Registration status:	Health, Standard 01/03/2005
Definition:	The main drug, as stated by the client, that has led a person to seek treatment from the service, as represented by a code.
Context:	Required as an indicator of the client's treatment needs.
Data Element Concept:	Episode of treatment for alcohol and other drugs—drug of concern

Value domain attributes

Representational attributes

Classification scheme:	Australian Standard Classification of Drugs of Concern 2000
Representation class:	Code
Data type:	String
Format:	NNNN
Maximum character length:	4

Supplementary values:

Value	Meaning
0005	Opioid analgesics not further defined
0006	Psychostimulants not further defined

Collection and usage attributes

Guide for use:

The Australian Standard Classification of Drugs of Concern (ASCDC) provides a number of supplementary codes that have specific uses and these are detailed within the ASCDC e.g. 0000 = inadequately described.

Other supplementary codes that are not already specified in the ASCDC may be used in National Minimum Data Sets (NMDS) when required. In the Alcohol and other drug treatment service NMDS, two additional supplementary codes have been created which enable a finer level of detail to be captured:

CODE 0005 Opioid analgesics not further defined

This code is to be used when it is known that the client's principal drug of concern is an opioid but the specific opioid used is not known. The existing code 1000 combines opioid analgesics and non-opioid analgesics together into Analgesics nfd and the finer level of detail, although known, is lost.

CODE 0006 Psychostimulants not further defined

This code is to be used when it is known that the client's principal drug of concern is a psychostimulant but not which

type. The existing code 3000 combines stimulants and hallucinogens together into Stimulants and hallucinogens nfd and the finer level of detail, although known, is lost.

Psychostimulants refer to the types of drugs that would normally be coded to 3100-3199, 3300-3399 and 3400-3499 categories plus 3903 and 3905.

Data element attributes

Collection and usage attributes

Guide for use:

The principal drug of concern should be the main drug of concern to the client and is the focus of the client's treatment episode. If the client has been referred into treatment and does not nominate a drug of concern, then the drug involved in the client's referral should be chosen.

Collection methods:

To be collected on commencement of the treatment episode.

For clients whose treatment episode is related to the alcohol and other drug use of another person, this metadata item should not be collected.

Source and reference attributes

Submitting organisation:

Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references:

Supersedes Principal drug of concern, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB)

Implementation in Data Set Specifications:

Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Alcohol and other drug treatment services NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Principal role—health profession

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—principal role, health profession code N
METeOR identifier:	375557
Registration status:	Health, Standard 10/12/2009
Definition:	The role in which the registered health professional spent the most time in the profession, in the week before registration, as represented by a code.
Data Element Concept:	Registered health professional—principal role

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Clinician
2	Administrator
3	Teacher/educator
4	Researcher
5	Other
Supplementary values: 9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 CLINICIAN

A clinician is a person mainly involved in the area of clinical practice. That is the 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 ADMINISTRATOR

An administrator in a health profession is a person whose main job is in an administrative capacity in the profession, such as directors of nursing, medical superintendents, medical advisers in government health authorities and health profession union administrators.

CODE 3 TEACHER/EDUCATOR

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 RESEARCHER

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.

CODE 5 OTHER

Other roles include Public health/health promotion, Occupational health, Environmental health, and all other roles not covered by codes 1-4 above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:

This data element is applicable to health professionals who were employed in the registered profession in Australia.

The health professional may be employed or self-employed in the profession.

Registered health professionals on leave at the time of registration are asked to report their usual principal role.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

Supersedes Health professional—principal role, code N Health, Superseded 10/12/2009

Implementation in Data Set Specifications:

Main job of registered chiropractor cluster Health, Standard 10/12/2009

Main job of registered dental and allied dental health professional cluster Health, Standard 10/12/2009

Main job of registered medical professional cluster Health, Standard 10/12/2009

Main job of registered midwife cluster Health, Standard 10/12/2009

Main job of registered nursing professional cluster Health, Standard 10/12/2009

Main job of registered optometrist cluster Health, Standard 10/12/2009

Main job of registered osteopath cluster Health, Standard 10/12/2009

Main job of registered pharmacist cluster Health, Standard 10/12/2009

Main job of registered physiotherapist cluster Health, Standard

10/12/2009

Main job of registered podiatrist cluster Health, Standard 10/12/2009

Main job of registered psychologist cluster Health, Standard 10/12/2009

Second job of registered chiropractor cluster Health, Standard 10/12/2009

Second job of registered dental and allied dental health professional cluster Health, Standard 10/12/2009

Second job of registered medical professional cluster Health, Standard 10/12/2009

Second job of registered midwife cluster Health, Standard 10/12/2009

Second job of registered nursing professional cluster Health, Standard 10/12/2009

Second job of registered optometrist cluster Health, Standard 10/12/2009

Second job of registered osteopath cluster Health, Standard 10/12/2009

Second job of registered pharmacist cluster Health, Standard 10/12/2009

Second job of registered physiotherapist cluster Health, Standard 10/12/2009

Second job of registered podiatrist cluster Health, Standard 10/12/2009

Second job of registered psychologist cluster Health, Standard 10/12/2009

Procedure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—procedure, code (ACHI 7th edn) NNNNN-NN
METeOR identifier:	391349
Registration status:	Health, Standard 22/12/2009
Definition:	A clinical intervention represented by a code 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.
Data Element Concept:	Episode of admitted patient care—procedure

Value domain attributes

Representational attributes

Classification scheme:	Australian Classification of Health Interventions (ACHI) 7th edition
Representation class:	Code
Data type:	Number
Format:	NNNNN-NN
Maximum character length:	7

Data element attributes

Collection and usage attributes

Collection methods:	Record and code all procedures undertaken during the episode of care in accordance with the ACHI (7th edition). Procedures are derived from and must be substantiated by clinical documentation.
Comments:	The National Centre for Classification in Health advises the National Health Information Standards and Statistics Committee of relevant changes to the ACHI.

Source and reference attributes

Origin:	National Centre for Classification in Health National Health Information Standards and Statistics Committee

Relational attributes

Related metadata references:

Supersedes Episode of admitted patient care—procedure, code (ACHI 6th edn) NNNNN-NN Health, Superseded 22/12/2009

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v 6) NN Health, Standard 22/12/2009

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v 6) ANNA Health, Standard 22/12/2009

Implementation in Data Set Specifications:

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Proficiency in spoken English

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—proficiency in spoken English, code N
METeOR identifier:	270203
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 10/02/2006
Definition:	A person's self-assessed level of ability to speak English, as represented by a code.
Data Element Concept:	Person—proficiency in spoken English

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
0	Not applicable (persons under 5 years of age or who speak only English)
1	Very well
2	Well
3	Not well
4	Not at all

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 0 Not applicable (persons under 5 years of age or who speak only English)

Not applicable, is to be used for people under 5 year of age and people who speak only English.

CODE 9 Not stated/inadequately described

Not stated/inadequately described, is not to be used on primary collection forms. It is primarily for use in administrative collections when transferring data from data sets where the item has not been collected.

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

Source and reference attributes

Reference documents: Standards for Statistics on Cultural and Language Diversity 1999. Cat. no. 1289.0. Canberra: ABS.

Data element attributes

Collection and usage attributes

Collection methods: This metadata item is only intended to be collected if a person has a main language other than English spoken at home; and/or first language spoken is not English.

Recommended question:

How well do you speak English? (tick one)

1. Very well

2. Well

3. Not well

4. 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 metadata item does not purport to be a technical assessment of proficiency but is a self-assessment in the four broad categories outlined above.

This metadata item is not relevant to and should not be collected for persons under the age of five years.

While agencies are encouraged to use the recommended question described above, it is acknowledged that this is not always possible in practice. For example, where the data collection is a by-product of the provision of a health or community service, the information may be ascertained using different means. However, this standard should be used wherever practically possible.

Comments: This metadata item identifies those people who may suffer disadvantage in terms of their ability to access services due to lack of ability in the spoken English language. This information can be used to target the provision of services to people whose lack of ability in spoken English is potentially a barrier to gaining access to government programs and services.

In conjunction with Indigenous status, the main language other than English spoken at home and the country of birth, this metadata item forms the minimum core set of cultural and language indicators recommended by the Australian Bureau of Statistics.

Source and reference attributes

Origin: National Health Data Committee

National Community Services Data Committee

Relational attributes

Related metadata references:

See also Person—main language other than English spoken at home, code (ASCL 2005) NN{NN} Health, Standard 08/02/2006, Community services, Standard 29/04/2006, Housing assistance, Standard 10/02/2006

See also Person—country of birth, code (SACC 1998) NNNN Health, Superseded 01/10/2008, Community services, Superseded 02/06/2008, Housing assistance, Superseded 24/11/2008

Supersedes Proficiency in spoken English, version 2, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005.pdf (18.6 KB)

Progesterone receptor assay results

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—progesterone receptor assay results, code N
METeOR identifier:	291341
Registration status:	Health, Standard 13/06/2004
Definition:	The results of progesterone receptor assay at the time or diagnosis of the primary breast tumour, as represented by a code.
Data Element Concept:	Person with cancer—progesterone receptor assay results

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Test done, results positive (progesterone receptor positive)
	2	Test done, results negative (Progesterone receptor negative)
Supplementary values:	0	Test not done (test not ordered or not performed)
	8	Test done but results unknown
	9	Unknown

Data element attributes

Collection and usage attributes

Collection methods: The Australian Cancer Network Working Party established to develop guidelines for the pathology reporting of breast cancer recommends that hormone receptor assays be performed on all cases of invasive breast carcinoma. The report should include:

- the percentage of nuclei staining positive and the predominant staining intensity (low, medium, high), and
- a conclusion as to whether the assay is positive or negative.

Source and reference attributes

Origin:	Royal College of Pathologists of Australasia Australian Cancer Network Commission on Cancer American College of Surgeons
Reference documents:	Royal College of Pathologists of Australasia Manual of Use and Interpretation of Pathology Tests: Third Edition Sydney (2001)

Australian Cancer Network Working Party The pathology reporting of breast cancer. A guide for pathologists, surgeons and radiologists Second Edition Sydney (2001)

Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:

Supersedes Progesterone receptor assay status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.9 KB)

Implementation in Data Set Specifications:

Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Superseded 06/03/2009

Cancer (clinical) DSS Health, Superseded 22/12/2009

Cancer (clinical) DSS Health, Standard 22/12/2009

Proteinuria status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—proteinuria status, code N{.N}
METeOR identifier:	270346
Registration status:	Health, Standard 01/03/2005
Definition:	Whether there is a presence of excessive protein in the urine of the person, as represented by a code.
Data Element Concept:	Person—proteinuria status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N{.N}
Maximum character length:	2

Permissible values:

Value	Meaning
1	Negative for protein
1.1	Microalbuminuria present
1.2	Microalbuminuria not present
1.3	Microalbuminuria not tested
2	Proteinuria
3	Not tested

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Negative for protein

Negative for proteinuria - less than 1 plus on dipstick-testing or excretion of 300 mg or less of protein from 24-hour urine collection.

CODE 1.1 Microalbuminuria present

Microalbuminuria present

CODE 1.2 Microalbuminuria not present

Microalbuminuria not present

CODE 1.3 Microalbuminuria not tested

Microalbuminuria not tested

CODE 2 Proteinuria

Proteinuria - one or more pluses of protein in dipstick urinalysis or for a 24-hour urine collection, where the patient excretes more than 300 mg/per day of protein.

	CODE 3 Not tested
	Not tested - no urinalysis for proteinuria was taken.
Collection methods:	Where laboratory testing is used to determine Proteinuria status the categorisation must be substantiated by clinical documentation such as an official laboratory report.

Data element attributes

Collection and usage attributes

Collection methods:	Dipstick testing can be used to test for protein in a urine specimen. Proteinuria (i.e. excessive protein in the urine) on dipstick urinalysis is described as one or more pluses of protein and for a 24-hour urine collection where the patient excretes more than 300 mg/day of protein. Microalbuminuria can be determining using any one of the following tests: spot urine, timed urine (24-hour collection) or albumin/creatinine ratio. Although the presence of microalbuminuria does not warrant categorisation as proteinuria, it is clinically significant in the diagnosis and treatment of diabetes.
Comments:	In settings where the monitoring of a person's health is ongoing and where a measure can change over time (such as general practice), the Patient—diagnosis date, DDMMYYYY should be recorded.

Source and reference attributes

Submitting organisation:	Cardiovascular Data Working Group

Relational attributes

Related metadata references:	Supersedes Proteinuria - status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.7 KB)
Implementation in Data Set Specifications:	Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006 Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007 Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009 Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Provider occupation category (self-identified) (ANZSCO 1st edition)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Individual service provider—occupation (self-identified), code (ANZSCO 1st edition) N[NNN]{NN}
Synonymous names:	Health care provider field of practice
METeOR identifier:	350896
Registration status:	Health, Standard 04/07/2007 Community services, Standard 27/03/2007
Definition:	A health care occupation that an individual provider identifies as being one in which they provide a significant amount of services, as represented by a code.
Data Element Concept:	Individual service provider—occupation (self-identified)

Value domain attributes

Representational attributes

Classification scheme:	Australian and New Zealand Standard Classification of Occupations, First edition, 2006
Representation class:	Code
Data type:	Number
Format:	N[NNN]{NN}
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:	The following is a list of the more common health care occupations, however, it is not intended to represent all the possible health care occupations: Aboriginal and Torres Strait Islander Health Worker (ANZSCO code 411511) Acupuncturist (ANZSCO code 252211) Aged or disabled carer (ANZSCO code 423111) Ambulance officer (ANZSCO code 411111) Anaesthetist (ANZSCO code 253211) Audiologist (ANZSCO code 252711) Chiropractor (ANZSCO code 252111) Clinical psychologist (ANZSCO code 272311) Complementary Health Therapists n.e.c. (ANZSCO code 252299) Dental assistant (ANZSCO code 423211)

Dental hygienist (ANZSCO code 411211)

Dental specialist (ANZSCO code 252311)

Dental technician (ANZSCO code 411213)

Dental therapist (ANZSCO code 411214)

Dentist (ANZSCO code 252312)

Dermatologist(ANZSCO code 253911)

Dietician (ANZSCO code 251111)

Drug and Alcohol Counsellor (ANZSCO code 272112)

Enrolled nurse (ANZSCO code 411411)

General medical practitioner (ANZSCO code 253111)

Health professionals (ANZSCO code 25)

Hospital pharmacist (ANZSCO code 251511)

Intensive care ambulance paramedic (AUS) / ambulance paramedic (NZ) (ANZSCO code 411112)

Massage therapist (ANZSCO code 411611)

Medical diagnostic radiographer (ANZSCO code 251211)

Medical practitioners n.e.c. (ANZSCO code 253999)

Medical radiation therapist (ANZSCO code 251212)

Midwife (ANZSCO code 254111)

Naturopath (ANZSCO code 252213)

Nuclear medicine technologist (ANZSCO code 251213)

Nurse educator (ANZSCO code 254211)

Nurse manager (ANZSCO code 254311)

Nurse practitioner (ANZSCO code 254411)

Nurse researcher (ANZSCO code 254212)

Nursing assistant support worker (ANZSCO code 423312)

Occupational therapist (ANZSCO code 252411)

Ophthalmologist (ANZSCO code 253914)

Optometrist (ANZSCO code 251411)

Orthoptist (ANZSCO code 251412)

Orthotist or Prosthetist (ANZSCO code 251912)

Osteopath (ANZSCO code 252112)

Paediatrician (ANZSCO code 253321)

Pathologist (ANZSCO code 253915)

Physiotherapist (ANZSCO code 252511)

Podiatrist (ANZSCO code 252611)

Psychiatrist (ANZSCO code 253411)

Psychologists n.e.c. (ANZSCO code 272399)

Radiologist (ANZSCO code 253916)

Registered nurse (developmental disability)(ANZSCO code 254416)

Registered nurse (mental health)(ANZSCO code 254422)

Registered Nurses n.e.c. (ANZSCO code 254499)

Rehabilitation counsellor (ANZSCO code 272114)

Retail pharmacist (ANZSCO code 251513)

Social worker (ANZSCO code 272511)

Sonographer (ANZSCO code 251214)

Specialist physician (general medicine) (ANZSCO code 253311)

Speech pathologist (AUS) / speech language therapist (NZ) (ANZSCO code 252712)

Surgeon (general) (ANZSCO code 253511)

Therapy aide (ANZSCO code 423314)

Collection methods:

Data is collected at the time a health care provider identification record is created.

Multiple instances of health care occupation may be collected where the individual provides a significant amount of services in more than one category. For example, a dentist who is also a medical practitioner may practice as both.

Record as many as apply.

Accurate data are best achieved using computer assisted coding. A computer assisted coding system is available from the ABS to assist in coding occupational data to ANZSCO codes.

Data coded at the 4-digit and 6-digit level will provide more detailed information than that collected at the higher levels and may be more useful. However, the level at which data are coded and reported will depend on the purpose of collecting this information.

Comments:

ANZSCO defines 'occupation' as 'a set of jobs with similar sets of tasks'. Operationally this is defined as 'a collection of jobs which are sufficiently similar in their main tasks to be grouped together for purposes of the classification'. Job is defined as 'a set of tasks designed to be performed by one individual for a wage or salary'.

Source and reference attributes

Origin:

AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia.

Reference documents:

AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia.

Relational attributes

Related metadata references:

Supersedes Individual service provider—occupation (self-identified), code (ASCO 2nd edn) N[NNN]{-NN} Health, Superseded 04/07/2007, Community services, Superseded 27/03/2007

Implementation in Data Set Specifications:

Health care provider identification DSS Health, Superseded 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Provider occupation end date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Individual service provider—occupation end date, DDMMYYYY
Synonymous names:	Health care provider field of practice end date
METeOR identifier:	289053
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The date on which an individual health care provider ceased practising in an identified occupation.
Data Element Concept:	Individual service provider—occupation end date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	Enter the date using day, month and year. In the AS4846 Health Care Provider Identification, the Australian Standard Health Care Provider Field of Practice End Date mandates the use of a Date Accuracy Indicator. This is not compulsory with the use of this data element.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

Related metadata references:	See also Date—accuracy indicator, code AAA Health, Standard 04/05/2005, Community services, Standard 30/09/2005
Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Superseded 03/12/2008 Health care provider identification DSS Health, Standard 03/12/2008

Provider occupation start date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Individual service provider—occupation start date, DDMMYYYY
Synonymous names:	Health care provider field of practice start date
METeOR identifier:	289059
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The date on which an individual health care provider commenced practising in an identified occupation.
Data Element Concept:	Individual service provider—occupation start date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	Enter the date using day, month and year. In the AS4846 Health Care Provider Identification, the Australian Standard Health Care Provider Field of Practice Start Date mandates the use of a Date Accuracy Indicator. This is not compulsory with the use of this data element.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

Related metadata references:	See also Date—accuracy indicator, code AAA Health, Standard 04/05/2005, Community services, Standard 30/09/2005
Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Superseded 03/12/2008 Health care provider identification DSS Health, Standard 03/12/2008

Purchase of goods and services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Organisation—purchase of goods and services, total Australian currency NNNNN.N
METeOR identifier:	359935
Registration status:	Health, Standard 05/12/2007
Definition:	Expenses of an organisation consisting mainly of purchases of goods and services, in Australian currency.
Data Element Concept:	Organisation—purchase of goods and services

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	NNNNN.N
Maximum character length:	6
Unit of measure:	Australian currency (AU$)

Source and reference attributes

Submitting organisation:	Health Expenditure Advisory Committee

Data element attributes

Collection and usage attributes

Guide for use:

Expenses relating to purchases of goods and services are to be reported in millions to the nearest 100,000 e.g. $4,064,000 should be reported as $4.1 million.

When revenue from transactions are offset against expenses from transactions, the result equates to the net operating balance in accordance with Australian Accounting Standards Board 1049 (September 2006).

Includes:

- administrative expenses (excluding workers compensation premiums and payouts)
- domestic services
- drug supplies
- food supplies
- grants
- medical and surgical supplies
- patient transport
- payments to visiting medical officers

- repairs and maintenance
- social benefits
- subsidy expenses
- other expenses (includes contracted care services purchased from private hospitals)

Collection methods:

Data are collected and nationally collated for the reporting period - the financial year ending 30th June each year.

In accounting terms, expenses are consumptions or losses of future economic benefits in the form of reductions in assets or increases in liabilities of the entity (other than those relating to distributions to owners) that result in a decrease in equity or net worth during the reporting period.

Expenses relating to purchases of goods and services are to be reported for the *Health industry relevant organisation type* and *Typeof health and health related functions* data elements.

Health industry relevant organisation type

State and territory health authorities are **NOT** to report the following codes:

Codes 106–109; 111; 115–119; 123; 201 and 203

Type of health and health related functions

State and territory health authorities are **NOT** to report the following codes:

Codes 199; 299; 303–305; 307; 499; 503–504; 599; 601–603; 688; 699

Comments:

In accounting terms, expenses are consumptions or losses of future economic benefits in the form of reductions in assets or increases in liabilities of the entity (other than those relating to distributions to owners) that result in a decrease in equity or net worth during the reporting period.

Source and reference attributes

Submitting organisation:

Health Expenditure Advisory Committee

Origin:

Australian Bureau of Statistics: Government Finance Statistics 1998, Cat. No. 5514.0.

Australian Bureau of Statistics 2006. Australian System of Government Finance Statistics: Concepts, sources and methods, 2005. Cat. no. 5514.0.55.001 Canberra: ABS.

Australian Accounting Standards Board 1049, September 2006, <www.aasb.com.au>

Relational attributes

Related metadata references:

Is used in the formation of Organisation—expenses, total Australian currency NNNNN.N Health, Standard 05/12/2007

Implementation in Data Set Specifications:

Government health expenditure organisation expenditure data cluster Health, Superseded 03/12/2008

Government health expenditure organisation expenditure data element cluster Health, Standard 01/04/2009

Government health expenditure organisation expenditure

purchase of goods and services data element cluster Health, Superseded 01/04/2009

Government health expenditure organisation expenditure purchase of goods and services data element cluster Health, Standard 01/04/2009

Quality accreditation/certification standard—Australian Council on Healthcare Standards EQuIP

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—quality accreditation/certification standard indicator (Australian Council on Healthcare Standards EQuIP), code N
METeOR identifier:	302372
Registration status:	Health, Standard 14/09/2005
Definition:	Whether the Australian Council on Healthcare Standards EQuIP standard has been met by the hospital establishment as a whole, as represented by a code.
Data Element Concept:	Establishment—quality accreditation/certification standard indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

Report the status code as at 30 June.

Code 1 Yes

Record if the hospital establishment is accredited or compliant with the standard.

Code 2 No

Record if the hospital establishment is not accredited or compliant with the standard.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Establishment—quality accreditation/certification standard status (Australian Council on Healthcare Standards EQuIP), code N Health, Superseded 14/09/2005

Quality accreditation/certification standard—Australian Quality Council

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—quality accreditation/certification standard indicator (Australian Quality Council), code N
METeOR identifier:	302374
Registration status:	Health, Standard 14/09/2005
Definition:	Whether the Australian Quality Council standard has been met by the hospital establishment as a whole, as represented by a code.
Data Element Concept:	Establishment—quality accreditation/certification standard indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

Report the status code as at 30 June.

Code 1 Yes

Record if the hospital establishment is accredited or compliant with the standard.

Code 2 No

Record if the hospital establishment is not accredited or compliant with the standard.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Establishment—quality accreditation/certification standard status (Australian Quality Council), code N Health, Superseded 14/09/2005

Quality accreditation/certification standard—ISO 9000 quality family

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—quality accreditation/certification standard indicator (International Organisation for Standardisation 9000 quality family), code N
METeOR identifier:	302377
Registration status:	Health, Standard 14/09/2005
Definition:	Whether the International Organisation for Standardisation 9000 quality family standard has been met by the hospital establishment as a whole, as represented by a code.
Data Element Concept:	Establishment—quality accreditation/certification standard indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

Report the status code as at 30 June.

Code 1 Yes

Record if the hospital establishment is accredited or compliant with the standard.

Code 2 No

Record if the hospital establishment is not accredited or compliant with the standard.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Establishment—quality accreditation/certification standard status (International Organisation for Standardisation 9000 quality family), code N Health, Superseded 14/09/2005

Quality accreditation/certification standard—Quality Improvement Council

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—quality accreditation/certification standard indicator (Quality Improvement Council), code N
METeOR identifier:	302379
Registration status:	Health, Standard 14/09/2005
Definition:	Whether the Quality Improvement Council standard has been met by the hospital establishment as a whole, as represented by a code.
Data Element Concept:	Establishment—quality accreditation/certification standard indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

Report the status code as at 30 June.

Code 1 Yes

Record if the hospital establishment is accredited or compliant with the standard.

Code 2 No

Record if the hospital establishment is not accredited or compliant with the standard.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Establishment—quality accreditation/certification standard status (Quality Improvement Council), code N Health, Superseded 14/09/2005

Radiotherapy treatment type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—radiotherapy treatment type, code N
METeOR identifier:	291438
Registration status:	Health, Standard 13/06/2004
Definition:	The type of radiation therapy used in initial treatment of the cancer, as represented by a code.
Data Element Concept:	Cancer treatment—radiotherapy treatment type

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Permissible values:	Value	Meaning
	1	External radiotherapy treatment given
	2	Brachytherapy (radioactive implants)
	3	Unsealed radioisotopes
Supplementary values:	0	No radiotherapy treatment given
	9	Radiotherapy was administered but method was not stated

Data element attributes

Collection and usage attributes

Collection methods:

If codes 1, 2, 3 or 9 are used, the amount of radiation received should also be collected.

Most external beam radiotherapy is delivered on an outpatient basis.

CODE 2 Brachytherapy (radioactive implants)

This code is likely to be listed as a procedure for admitted patients.

Source and reference attributes

Submitting organisation:	National Cancer Control Initiative
Origin:	Commission on Cancer, American College of Surgeons New South Wales Health Department
Reference documents:	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998) Public Health Division NSW Clinical Cancer Data Collection for

Outcomes and Quality. Data Dictionary Version 1 Sydney NSW Health Dept (2001)

Relational attributes

Related metadata references:

Supersedes Radiotherapy treatment type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.0 KB)

See also Cancer treatment—radiation dose received, total Gray N[NNNN] Health, Standard 13/06/2004

Implementation in Data Set Specifications:

Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Superseded 06/03/2009

Cancer (clinical) DSS Health, Superseded 22/12/2009

Cancer (clinical) DSS Health, Standard 22/12/2009

Reason for cessation of treatment episode for alcohol and other drugs

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—cessation reason, code N[N]
METeOR identifier:	270011
Registration status:	Health, Standard 01/03/2005
Definition:	The reason for the client ceasing to receive a treatment episode from an alcohol and other drug treatment service, as represented by a code.
Data Element Concept:	Episode of treatment for alcohol and other drugs—cessation reason

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
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

Supplementary values:

99	Not stated/inadequately described

Collection and usage attributes

Guide for use:	To be collected on cessation of a treatment episode. Codes 1 to 12

listed above are set out as follows to enable a clearer picture of which codes are to be used for what purpose:

Treatment completed as planned:

CODE 1 Treatment completed

Client ceased to participate:

CODE 6 Ceased to participate against advice

CODE 7 Ceased to participate without notice

CODE 8 Ceased to participate involuntary (non-compliance)

CODE 9 Ceased to participate at expiation

Ceased to participate at expiation:

CODE 11 Drug court and /or sanctioned by court diversion service

CODE 12 Imprisoned, other than drug court sanctioned

Treatment not completed (other):

CODE 2 Change in main treatment type

CODE 3 Change in the delivery setting

CODE 4 Change in the principal drug of concern

CODE 5 Transferred to another service provider

Treatment ceased by mutual agreement:

CODE 10 Ceased to participate by mutual agreement

CODE 1 Treatment completed

This code is to be used when all of the immediate goals of the treatment have been completed as planned. Includes situations where the client, after completing this treatment, either does not commence any new treatment, commences a new treatment episode with a different main treatment or principal drug, or is referred to a different service provider for further treatment.

CODE 2 Change in main treatment type

A treatment episode will end if, prior to the completion of the existing treatment, there is a change in the main treatment type for alcohol and other drugs. See also Code 10.

CODE 3 Change in the delivery setting

A treatment episode may end if, prior to the completion of the existing treatment, there is a change in the treatment delivery setting for alcohol and other drugs. See also Code 10 and the Guide for use section in metadata item Episode of treatment for alcohol and other drugs.

CODE 4 Change in the principal drug of concern

A treatment episode will end if, prior to the completion of the existing treatment, there is a change in the principal drug of concern. See also Code 10.

CODE 5 Transferred to another service provider

This code 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. Excludes situations where the original treatment was completed before the client transferred to a different provider for other treatment (use Code 1).

CODE 6 Ceased to participate against advice

This code 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 Ceased to participate without notice

This code refers to situations where the client ceased to receive treatment without notifying the service provider of their intention to no longer participate.

CODE 8 Ceased to participate involuntary (non-compliance)

This code 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 Ceased to participate at expiation

This code 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 further treatment.

CODE 10 Ceased to participate by mutual agreement

This code 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. Only to be used when Code 2, 3 or 4 is not applicable.

CODE 11 Drug court and/or sanctioned by court diversion service

This code applies to drug court and/or court diversion service clients who are sanctioned back into jail for non-compliance with the program.

CODE 12 Imprisoned, other than drug court sanctioned

This code applies to clients who are imprisoned for reasons other than Code 11.

Data element attributes

Collection and usage attributes

Comments: 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.

Source and reference attributes

Submitting organisation: Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references:

Supersedes Reason for cessation of treatment episode for alcohol and other drugs, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.4 KB)

Implementation in Data Set Specifications:

Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Alcohol and other drug treatment services NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Reason for non prescription of pharmacotherapy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—reason for non prescription of pharmacotherapy, code N
METeOR identifier:	347222
Registration status:	Health, Standard 01/10/2008
Definition:	The reason a pharmacotherapy was not prescribed for a person, as represented by a code.
Data Element Concept:	Person—reason for non prescription of pharmacotherapy

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Not indicated
2	Contraindicated

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Not indicated

Record this code when a pharmacotherapy was not prescribed because it was not necessary to the treatment of the person.

CODE 2 Contraindicated

Record this code when a pharmacotherapy was not prescribed because of a condition or factor that increases the risks involved in using the pharmacotherapy. Examples of contraindications are allergy, intolerance, medical condition.

Collection methods:

For each type of pharmacotherapy not prescribed for the person, record whether it was not indicated or contraindicated.

Relational attributes

Related metadata references:

See also Person with acute coronary syndrome—pharmacotherapy type prescribed in hospital, code N[N] Health, Standard 01/10/2008

Implementation in Data Set Specifications:

Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008

Conditional obligation:

To be provided for each of the pharmacotherapies listed in the data element *'Pharmacotherapy type prescribed for acute coronary syndrome in hospital'* not prescribed.

Reason for readmission—acute coronary syndrome

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—reason for readmission following acute coronary syndrome episode, code N[N]
METeOR identifier:	359404
Registration status:	Health, Standard 01/10/2008
Definition:	The main reason for the **admission**, to any hospital, of a person within 28 days of discharge from an episode of admitted patient care for acute coronary syndrome, as represented by a code.
Data Element Concept:	Person—reason for readmission following acute coronary syndrome episode

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	ST-segment-elevation myocardial infarction
2	non-ST-segment-elevation ACS with high-risk features
3	non-ST-segment-elevation ACS with intermediate-risk features
4	non-ST-segment-elevation ACS with low-risk features
5	Percutaneous coronary intervention (PCI)
6	Coronary artery bypass graft (CABG)
7	Heart Failure (without MI)
8	Arrhythmia (without MI)

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 ST-segment-elevation myocardial infarction

This code is used when the reason for admission is persistent ST elevation of >=1mm in two contiguous limb leads, or ST elevation of >=2mm in two contiguous chest leads, or with new left bundle-branch block (BBB) pattern on the ECG.

CODE 2 Non-ST-segment-elevation ACS with high-risk features

This code is used when the reason for admission is clinical

features consistent with an acute coronary syndrome with high-risk features which include any of the following:

- repetitive or prolonged (> 10 minutes) ongoing chest pain or discomfort;
- elevated level of at least one cardiac biomarker (troponin or creatine kinase-MB isoenzyme);
- persistent or dynamic ECG changes of ST segment depression >= 0.5mm or new T wave >= 2mm;
- transient ST-segment elevation (>= 0.5 mm) in more than 2 contiguous leads;
- haemodynamic compromise: Blood pressure < 90 mmHg systolic, cool peripheries, diaphoresis, Killip Class > 1, and/or new onset mitral regurgitation;
- sustained ventricular tachycardia;
- syncope;
- left ventricular systolic dysfunction (left ventricular ejection fraction < 0.40);
- prior percutaneous coronary intervention within 6 months or prior coronary artery bypass surgery;
- presence of known diabetes (with typical symptoms of ACS); or
- chronic kidney disease (estimated glomerular filtration rate < 60mL/minute) (with typical symptoms of ACS).

CODE 3 Non-ST-segment-elevation ACS with intermediate-risk features

This code is used when the reason for admission is clinical features consistent with an acute coronary syndrome and any of the following intermediate-risk features AND NOT meeting the criteria for high-risk ACS:

- chest pain or discomfort within the past 48 hours that occurred at rest, or was repetitive or prolonged (but currently resolved);
- age greater than 65yrs;
- known coronary heart disease: prior myocardial infarction with left ventricular ejection fraction >= 0.40, or known coronary lesion more than >50% stenosed;
- no high-risk changes on electrocardiography (see high-risk features);
- two or more of the following risk factors: of known hypertension, family history, active smoking or hyperlipidaemia;
- presence of known diabetes (with atypical symptoms of ACS);
- chronic kidney disease (estimated glomerular filtration rate < 60mL/minute) (with atypical symptoms of ACS); or
- prior aspirin use.

CODE 4 Non-ST-segment-elevation ACS with low-risk features

This code is used when the reason for admission is clinical features consistent with an acute coronary syndrome without intermediate or high-risk features of non-ST-segment-elevation ACS. This includes onset of anginal symptoms within the last month, or worsening in severity or frequency of angina, or lowering of anginal threshold.

CODE 5 Percutaneous coronary intervention (PCI)

This code is used when the reason for admission is for a PCI, where the PCI is not immediately precipitated by a recurrent ischaemic event. If a recurrent ischaemic event precipitates a readmission with an associated PCI undertaken, one of codes 1-4 should be coded.

CODE 6 Coronary artery bypass graft (CABG)

This code is used when the reason for admission is for a CABG, where the CABG is not immediately precipitated by a recurrent ischaemic event. If a recurrent ischaemic event precipitates a readmission with an associated CABG undertaken, one of codes 1-4 should be coded.

CODE 7 Heart failure (without MI)

This code is used when the reason for admission is for the treatment of heart failure, where heart failure is not immediately precipitated by a recurrent ischaemic event. If a recurrent ischaemic event precipitates a readmission, one of codes 1-4 should be coded.

CODE 8 Arrhythmia (without MI)

This code is used when the reason for admission is for the treatment of an arrhythmia, where the arrhythmia is not immediately precipitated by a recurrent ischaemic event. If a recurrent ischaemic event precipitates a readmission, one of codes 1-4 should be coded.

Data element attributes

Collection and usage attributes

Guide for use:	To determine if this item should be collected ask the person being admitted if they have been discharged from an episode of admitted patient care for acute coronary syndrome within the last 28 days.
Comments:	This metadata item is designed to identify recurrent admissions following an initial presentation with acute coronary syndromes (ACS), not necessarily to the hospital responsible for the index admission.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Person—reason for readmission following acute coronary syndrome episode, code N[N] Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Reason for removal from elective surgery waiting list

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—reason for removal from a waiting list, code N
METeOR identifier:	269959
Registration status:	Health, Standard 01/03/2005
Definition:	The reason why a patient is removed from the elective surgery waiting list, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode—reason for removal from a waiting list

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Admitted as an elective patient for awaited procedure in this hospital or another hospital
2	Admitted as an emergency patient for awaited procedure in this hospital or another 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, but not as a patient of this hospital's waiting list
5	Surgery not required or declined
6	Transferred to another hospital's waiting list

Supplementary values:

Value	Meaning
9	Not known

Collection and usage attributes

Guide for use:

CODE 1 Admitted as an elective patient for awaited procedure in this hospital or another hospital

Patients undergoing the awaited procedure whilst admitted for another reason are to be coded this code.

CODE 2 Admitted as an emergency patient for awaited procedure in this hospital or another hospital

This code 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

CODE 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)

CODE 4 Treated elsewhere for awaited procedure, but not as a patient of this hospital's waiting list

CODE 5 Surgery not required or declined

These codes provide an indication of the amount of clerical audit of the waiting lists. Code 4 gives an indication of patients treated other than as a patient of the hospital's waiting list. The awaited procedure may have been performed as an emergency or as an elective procedure.

CODE 6 Transferred to another hospital's waiting list

This code identifies patients who were transferred from one hospital's elective surgery waiting list to that of another hospital. The waiting time on the waiting lists at the initial hospital and subsequent hospitals should be combined for national reporting.

CODE 9 Not known

This code identifies patients removed from the waiting list for reasons unknown.

Data element attributes

Source and reference attributes

Submitting organisation: Hospital Access Program Waiting Lists Working Group

Waiting Times Working Group

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Reason for removal from elective surgery waiting list, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.8 KB)

Implementation in Data Set Specifications: Elective surgery waiting times (removals data) NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2002

Implementation end date: 30/06/2006

Elective surgery waiting times (removals data) NMDS 2006-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2006

Implementation end date: 30/06/2009

Elective surgery waiting times (removals data) NMDS 2009- Health, Standard 03/12/2008

Implementation start date: 01/07/2009

Received radiation dose

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—radiation dose received, total Gray N[NNNN]
METeOR identifier:	291472
Registration status:	Health, Standard 13/06/2004
Definition:	The received dose of radiation measured in Gray (Gy) - ICRU.
Data Element Concept:	Cancer treatment—radiation dose received

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNN]
Maximum character length:	5

Supplementary values:

Value	Meaning
00000	No radiation therapy was administered
99999	Radiation therapy was administered but the dose is unknown

Unit of measure: Gray (Gy)

Data element attributes

Collection and usage attributes

Guide for use:

The International Commission on Radiation Units (ICRU) recommends recording doses at the axis point where applicable (opposed fields, four field box, wedged pairs and so on). The ICRU50 reference dose should be recorded for photon therapy if available, otherwise a description of the received dose at the centre of the planning target volume.

The ICRU58 should be recorded for brachytherapy.

For maximum consistency in this field the ICRU recommendations should be followed whenever possible.

Source and reference attributes

Submitting organisation:	National Cancer Control Initiative
Origin:	Commission on Cancer, American College of Surgeons
Reference documents:	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:	See also Cancer treatment—radiotherapy treatment type, code N Health, Standard 13/06/2004
	Supersedes Received radiation dose, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.6 KB)
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005
	Cancer (clinical) DSS Health, Superseded 06/03/2009
	Cancer (clinical) DSS Health, Superseded 22/12/2009
	Cancer (clinical) DSS Health, Standard 22/12/2009

Recurrent expenditure (indirect health care)—public health and monitoring services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (indirect health care) (public health and monitoring services) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270292
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure on indirect health care that is related to public health and monitoring services, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (indirect health care)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	To be provided at the state level. 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. 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. Record values up to hundreds of millions of dollars.

Comments: Resources Working Party members were concerned about the possibility of 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.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Indirect health care expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.1 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure (indirect health care)—central administrations

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (indirect health care) (central administrations) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270294
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure measured in Australian dollars on indirect health care related to central administrations, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (indirect health care)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	To be provided at the state level. Expenditures relating to central health administration, research and planning for central and regional offices of State, Territory and Commonwealth health authorities and related departments (e.g. the Department of Veterans' Affairs). Record values up to hundreds of millions of dollars. Rounded to the nearest whole dollar.
Comments:	Resources Working Party members were concerned about the possibility of 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.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Indirect health care expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.1 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure (indirect health care)—central and statewide support services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (indirect health care) (central and statewide support services) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270293
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure measured in Australian dollars on indirect health care related to central and statewide support services, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (indirect health care)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	To be provided at the state level. Public or registered services which provide central or statewide support services for residential establishments within the scope of the Public hospital establishments National Minimum 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. Record values up to hundreds of millions of dollars, rounded to the nearest whole dollar.
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.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Indirect health care expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.1 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure (indirect health care)—other

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (indirect health care) (other) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270295
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure in Australian dollars on health care that cannot be directly related to programs operated by a particular establishment and is not related to patient transport services, public health and monitoring services, central and statewide support services or central administrations, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (indirect health care)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	To be provided at the state level. Other: Any other indirect health care expenditure as defined above not catered for in the following categories: Patient transport services; Public health and monitoring services; Central and statewide support services; Central administrations. 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. Record values up to hundreds of millions of dollars, rounded to the nearest whole dollar.
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.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Indirect health care expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.1 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure (indirect health care)—patient transport services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (indirect health care) (patient transport services) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270291
Registration status:	Health, Standard 01/03/2005
Definition:	Expenditure measured in Australian dollars on indirect health care related to patient transport services, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (indirect health care)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	To be provided at the state level. 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. Record values up to hundreds of millions of dollars. Rounded to the nearest whole dollar.
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.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Indirect health care expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.1 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure (mental health)—non-salary operating costs

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)]
Synonymous names:	Non-salary operating costs excluding depreciation
METeOR identifier:	287979
Registration status:	Health, Standard 08/12/2004
Definition:	Total expenditure by a mental health establishment relating to non-salary operating items.
Data Element Concept:	Establishment—recurrent expenditure (non-salary operating costs)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Report all expenditure in thousands of dollars (i.e. $000s). 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. Depreciation is to be excluded from the non-salary operating costs.
Collection methods:	Non-salary recurrent expenditure, excluding depreciation, is to be reported by service setting (admitted patient care, residential care, ambulatory care). For the admitted patient care setting non-salary recurrent expenditure, excluding depreciation, is to be disaggregated by specialised mental health service program type and specialised mental health service target population, together. The sub-components of non-salary recurrent expenditure, and

depreciation, are to be reported at the organisation level for the Mental health establishments NMDS. However, if the organisation is not reporting on an accrual basis then it does not need to report depreciation.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Is formed using Establishment—recurrent expenditure (repairs and maintenance) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (superannuation employer contributions) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (visiting medical officer payments) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (medical and surgical supplies) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (food supplies) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (patient transport cost) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (interest payments) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (drug supplies) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (domestic services) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (other recurrent expenditure) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (administrative expenses) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health,

Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure (mental health)—salaries and wages

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (mental health)—recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)]
METeOR identifier:	296577
Registration status:	Health, Standard 08/12/2004
Definition:	Total salary and wage payments to all **staff** of a mental health establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:

Is formed using Establishment—recurrent expenditure (salaries and wages) (diagnostic and health professionals) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (salaries and wages) (registered nurses) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (salaries and wages) (other personal care staff) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (salaries and wages) (enrolled nurses) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (salaries and wages) (carer consultants) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is formed using Establishment—recurrent expenditure (salaries and wages) (consumer consultants) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is formed using Establishment—recurrent expenditure (salaries and wages) (administrative and clerical staff) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (salaries and wages) (domestic and other staff) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (salaries and wages) (salaried medical officers) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—administrative and clerical staff

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (administrative and clerical staff) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270275
Registration status:	Health, Standard 01/03/2005
Definition:	Salary and wage payments measured in Australian dollars to **administrative and other clerical staff** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB) Is used in the formation of Establishment (mental health)—recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—carer consultants

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (carer consultants) (financial year), total Australian currency N[N(8)]
METeOR identifier:	296531
Registration status:	Health, Standard 08/12/2004
Definition:	Salary and wage payments to **carer consultants** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Carer consultants are persons employed (or engaged via contract) on a part-time or full-time paid basis to represent the interests of carers and advocate for their needs. This implies the person received a salary or contract fee on a regular basis. It does not refer to arrangements where the carer only received reimbursements of expenses or occasional sitting fees for attendance at meetings.
Collection methods:	Note: This code is only to be reported for the Mental Health Establishments NMDS. For Public hospital establishments NMDS data are to be reported in a category according to specific state and territory arrangements.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Is used in the formation of Establishment (mental health)—recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—consultant psychiatrists and psychiatrists

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (consultant psychiatrists and psychiatrists) (financial year), total Australian currency N[N(8)]
METeOR identifier:	288767
Registration status:	Health, Standard 08/12/2004
Definition:	Salary and wage payments to **consultant psychiatrists** and **psychiatrists** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—consumer consultants

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (consumer consultants) (financial year), total Australian currency N[N(8)]
METeOR identifier:	296528
Registration status:	Health, Standard 08/12/2004
Definition:	Salary and wage payments to **consumer consultants** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Consumer consultants are persons employed (or engaged via contract) on a part-time or full-time paid basis to represent the interests of consumers and advocate for their needs. This implies the person received a salary or contract fee on a regular basis. It does not refer to arrangements where the consumer only received reimbursements of expenses or occasional sitting fees for attendance at meetings.
Collection methods:	Note: This code is only to be reported for the Mental Health Establishments NMDS. For Public hospital establishments NMDS data are to be reported in a category according to specific state and territory arrangements.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Is used in the formation of Establishment (mental health)—recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—diagnostic and health professionals

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (diagnostic and health professionals) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270274
Registration status:	Health, Standard 01/03/2005
Definition:	Salary and wage payments measured in Australian dollars to **diagnostic and health professionals** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB) Is used in the formation of Establishment (mental health)—recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—domestic and other staff

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (domestic and other staff) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270276
Registration status:	Health, Standard 01/03/2005
Definition:	Salary and wage payments measured in Australian dollars to **domestic and other staff** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB) Is used in the formation of Establishment (mental health)—recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—enrolled nurses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (enrolled nurses) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270270
Registration status:	Health, Standard 01/03/2005
Definition:	Salary and wage payments measured in Australian dollars to **enrolled nurses** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB) Is used in the formation of Establishment (mental health)—recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—occupational therapists

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (occupational therapists) (financial year), total Australian currency N[N(8)]
METeOR identifier:	288778
Registration status:	Health, Standard 08/12/2004
Definition:	Salary and wage payments to **occupational therapists** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—other diagnostic and health professionals

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (other diagnostic and health professionals) (financial year), total Australian currency N[N(8)]
METeOR identifier:	288786
Registration status:	Health, Standard 08/12/2004
Definition:	Salary and wage payments to **other diagnostic and health professionals** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—other medical officers

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (other medical officers) (financial year), total Australian currency N[N(8)]
METeOR identifier:	288776
Registration status:	Health, Standard 08/12/2004
Definition:	Salary and wage payments to **other medical officers** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Other medical officers are those who are neither registered as psychiatrists within the State or Territory nor formal trainees within the Royal Australian and New Zealand College of Psychiatrists Postgraduate Training Program.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—other personal care staff

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (other personal care staff) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270273
Registration status:	Health, Standard 01/03/2005
Definition:	Salary and wage payments measured in Australian dollars to **other personal care staff** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB) Is used in the formation of Establishment (mental health)—recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—psychiatry registrars and trainees

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (psychiatry registrars and trainees)(financial year), total Australian currency N[N(8)]
METeOR identifier:	288774
Registration status:	Health, Standard 08/12/2004
Definition:	Salary and wage payments to **psychiatry registrars and trainees** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—psychologists

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (psychologists) (financial year), total Australian currency N[N(8)]
METeOR identifier:	288784
Registration status:	Health, Standard 08/12/2004
Definition:	Salary and wage payments to **psychologists** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—registered nurses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (registered nurses) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270269
Registration status:	Health, Standard 01/03/2005
Definition:	Salary and wage payments measured in Australian dollars to **registered nurses** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB) Is used in the formation of Establishment (mental health)—recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—salaried medical officers

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (salaried medical officers) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270265
Registration status:	Health, Standard 01/03/2005
Definition:	Salary and wage payments measured in Australian dollars to **salaried medical officers** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB) Is used in the formation of Establishment (mental health)—recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—social workers

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (social workers) (financial year), total Australian currency N[N(8)]
METeOR identifier:	288780
Registration status:	Health, Standard 08/12/2004
Definition:	Salary and wage payments to **social workers** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—student nurses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (student nurses) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270271
Registration status:	Health, Standard 01/03/2005
Definition:	Salary and wage payments measured in Australian dollars to **student nurses** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	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. Note: This code is not to be reported for the Mental health establishments National Minimum Data Set.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—total

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270470
Registration status:	Health, Standard 01/03/2005
Definition:	Salary and wage payments measured in Australian dollars for all employees of the establishment (including contract staff employed by an agency, provided staffing data is also available).
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:

Record as currency up to hundreds of millions of dollars.

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

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB)

Implementation in Data Set Specifications:

Community mental health establishments NMDS 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—trainee/pupil nurses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (trainee/pupil nurses) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270272
Registration status:	Health, Standard 01/03/2005
Definition:	Salary and wage payments measured in Australian dollars to **trainee/pupil nurses** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006
	Implementation start date: 01/07/2005
	Implementation end date: 30/06/2006
	Public hospital establishments NMDS Health, Superseded 23/10/2006
	Implementation start date: 01/07/2006
	Implementation end date: 30/06/2007
	Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008
	Implementation start date: 01/07/2007
	Implementation end date: 30/06/2008
	Public hospital establishments NMDS 2008-2009 Health,

Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure—Department of Veterans' Affairs funded

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (Department of Veterans' Affairs funded), total Australian currency N[N(8)]
METeOR identifier:	377992
Registration status:	Health, Standard 02/12/2009
Definition:	Total recurrent expenditure measured in Australian dollars funded by block grants or activity payments provided by the Department of Veterans' Affairs (DVA) for provision of mental health services and payments made for mental health treatment and care of DVA clients.
Data Element Concept:	Establishment—recurrent expenditure (Department of Veterans' Affairs funded)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Australian dollars. Rounded to nearest whole dollar.
Collection methods:	DVA-funded expenditure to be reported only once and for the specific statistical unit level at which the expenditure is available. Where DVA-funded expenditure could be allocated to more than one level it is important to allocate it to the single most appropriate statistical unit level to avoid the possibility of counting the expended funds more than once. For example, funding provided for service delivery expenditure should be reported at the lowest statistical unit level possible only.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Establishment—recurrent expenditure (Department of Veterans' Affairs funded), total Australian currency N[N(8)] Health, Superseded 02/12/2009

Implementation in Data Set Specifications:	Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009 *Implementation start date:* 01/07/2010

Recurrent expenditure—National Mental Health Strategy funded

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (National Mental Health Strategy funded), total Australian currency N[N(8)]
METeOR identifier:	289502
Registration status:	Health, Standard 08/12/2004
Definition:	Total recurrent expenditure funded by monies allocated by the Commonwealth to the state or territory to assist in implementation of the National Mental Health Strategy.
Data Element Concept:	Establishment—recurrent expenditure (National Mental Health Strategy payments)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Australian dollars. Rounded to the nearest whole dollar.
Collection methods:	Report only the expenditure from those funds used to resource recurrent Expenditure on services within the scope of the NMDS—Mental Health Establishments. National Mental Health Strategy-funded expenditure to be reported only once and for the specific statistical unit level at which the expenditure actually occurred e.g. at the state, regional or organisational level.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	See also Establishment—recurrent expenditure (other revenue funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure—State or Territory health authority funded

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (state or territory health authority funded), total Australian currency N[N(8)]
METeOR identifier:	288965
Registration status:	Health, Standard 08/12/2004
Definition:	The total recurrent expenditure from funds provided by the State or Territory health authority which were used to support the delivery and/or administration of mental health services reported by the organisation, region or central administration.
Data Element Concept:	Establishment—recurrent expenditure (state or territory health authority funded)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Australian dollars. Rounded to nearest whole dollar. Includes specific mental health allocations as well as health funds appropriated for general or other specific purpose.
Collection methods:	State or Territory health authority-funded expenditure to be reported only once and for the specific statistical unit level at which the expenditure actually occurred e.g. at the state, regional or organisational level. Where State or Territory health authority-funded expenditure could be allocated to more than one level it is important to allocate it to the single most appropriate statistical unit level to avoid the possible of counting the expended funds more than once. For example, funding provided for service delivery expenditure should be reported at the lowest statistical unit level possible only.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

See also Establishment—recurrent expenditure (other revenue funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure—administrative expenses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (administrative expenses) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270107
Registration status:	Health, Standard 01/03/2005
Definition:	The expenditure measured in Australian dollars 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), for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (administrative expenses)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Rounded to the nearest whole dollar.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Administrative expenses, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.8 KB) Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (community mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health,

Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure—depreciation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (depreciation) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270279
Registration status:	Health, Standard 01/03/2005
Definition:	Depreciation charges measured in Australian dollars for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (depreciation)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Record values up to hundreds of millions of dollars. Rounded to the nearest whole dollar. Depreciation is to be reported by service setting (admitted patient care, residential care, ambulatory care). For admitted patient care settings, depreciation is to be disaggregated by specialised mental health service program type and specialised mental health service target population, together.
Comments:	With the long-term trend towards accrual accounting in the public sector, this metadata 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 for most public sector establishments and should be reported as a separate recurrent expenditure. Depreciation should be identified separately from other recurrent expenditure categories.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Depreciation, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)

Is used in the formation of Establishment (community mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health,

Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure—domestic services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (domestic services) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270283
Registration status:	Health, Standard 01/03/2005
Definition:	The costs measured in Australian dollars 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, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (domestic services)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Record values up to hundreds of millions of dollars. Rounded to the nearest whole dollar. Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers.
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.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Domestic services, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.6 KB) Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is used in the formation of Establishment (mental health) — recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is used in the formation of Establishment (community mental health) — recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health,

Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure—drug supplies

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (drug supplies) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270282
Registration status:	Health, Standard 01/03/2005
Definition:	The cost measured in Australian dollars of all drugs including the cost of containers, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (drug supplies)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Record values up to hundreds of millions of dollars. Rounded to the nearest whole dollar. Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Drug supplies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.7 KB) Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (community mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health,

Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure—food supplies

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (food supplies) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270284
Registration status:	Health, Standard 01/03/2005
Definition:	The cost measured in Australian dollars of all food and beverages but not including kitchen expenses such as utensils, cleaning materials, cutlery and crockery, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (food supplies)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Record values up to hundreds of millions of dollars. Rounded to the nearest whole dollar. Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Food supplies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.8 KB) Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (community mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health,

Standard 01/03/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health,

Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure—interest payments

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (interest payments) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270186
Registration status:	Health, Standard 01/03/2005
Definition:	Payments in Australian dollars 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, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (interest payments)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Record values up to hundreds of millions of dollars. Rounded to nearest whole dollar.
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.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Interest payments, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.9 KB)
	Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
	Is used in the formation of Establishment (mental health)—

recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is used in the formation of Establishment (community mental health) — recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure—medical and surgical supplies

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (medical and surgical supplies) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270358
Registration status:	Health, Standard 01/03/2005
Definition:	The cost in Australian dollars of all consumables of a medical or surgical nature (excluding drug supplies) but not including expenditure on equipment repairs, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (medical and surgical supplies)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers.
Collection methods:	Record values up to hundreds of millions of dollars. Rounded to nearest whole dollar.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Medical and surgical supplies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)
	Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
	Is used in the formation of Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
	Is used in the formation of Establishment (community mental health)—recurrent expenditure (non-salary operating costs)

(financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure—non-salary operating costs (excluding depreciation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (community mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270297
Registration status:	Health, Standard 01/03/2005
Definition:	Total expenditure relating to non-salary operating items, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (non-salary operating costs)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:

Record values up to hundreds of millions of dollars. Rounded to the nearest whole dollar.

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.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Non-salary operating costs, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.2 KB)

Is formed using Establishment—recurrent expenditure (administrative expenses) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (other recurrent expenditure) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (domestic services) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (drug supplies) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (interest payments) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (patient transport cost) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (food supplies) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (depreciation) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (medical and surgical supplies) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (visiting medical officer payments) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (superannuation employer contributions) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (repairs and maintenance) (financial year), total Australian currency

N[N(8)] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Community mental health establishments NMDS 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

Recurrent expenditure—other Commonwealth Government funded

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (other Commonwealth Government funded expenditure), total Australian currency N[N(8)]
METeOR identifier:	288031
Registration status:	Health, Standard 08/12/2004
Definition:	Total recurrent expenditure by an organisation, region or central administration funded from other revenue paid directly by the Commonwealth Government and used to resource recurrent expenditure on services within the scope of the NMDS—Mental Health Establishments.
Data Element Concept:	Establishment—recurrent expenditure (other Commonwealth Government funded expenditure)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Australian dollars. Rounded to nearest whole dollar. Includes expenditure where the funding is from nursing home and hostel subsidies for the care of patients in specialised mental health services, and any other special purpose grants including rural health support, education and training funds and incentive package funds made available under the Australian Health Care Agreements. Excludes expenditure funded by the Commonwealth under grants from the Department of Veterans' Affairs or from the National Mental Health Strategy.
Collection methods:	Other Commonwealth Government-funded expenditure to be reported only once and for the specific statistical unit level at which the expenditure actually occurred e.g. at the state, regional or organisational level. Where other Commonwealth Government-funded expenditure could be allocated to more than one level it is important to

allocate it to the single most appropriate statistical unit level to avoid the possible of counting the expended funds more than once. For example, funding provided for service delivery expenditure should be reported at the lowest statistical unit level possible only.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: See also Establishment—recurrent expenditure (other revenue funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Implementation in Data Set Specifications: Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure—other State or Territory funded

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (other state or territory funded expenditure), total Australian currency N[N(8)]
METeOR identifier:	288075
Registration status:	Health, Standard 08/12/2004
Definition:	The total recurrent expenditure from state or territory funding sources from government departments external to the health department portfolio which were used to support the delivery and/or administration of mental health services.
Data Element Concept:	Establishment—recurrent expenditure (other state or territory funded expenditure)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	State or territory-funded expenditure to be reported only once and for the specific statistical unit level at which the expenditure actually occurred, e.g. at the state, regional or organisational level.
Collection methods:	Where state or territory-funded expenditure could be allocated to more than one level it is important to allocate it to the single most appropriate statistical unit level to avoid the possible of counting the expended funds more than once. For example, funding provided for service delivery expenditure should be reported at the lowest statistical unit level possible only. Expenditure funded from all other revenue, excluding those reported separately, to be reported only once and for the specific statistical unit level at which the expenditure actually occurred e.g. at the state, regional or organisational level.

Relational attributes

Related metadata references:	See also Establishment—recurrent expenditure (other revenue funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure—other patient revenue funded

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (other patient revenue funded expenditure), total Australian currency N[N(8)]
METeOR identifier:	290583
Registration status:	Health, Standard 08/12/2004
Definition:	Recurrent expenditure funded from other revenue paid directly by patients or third parties, such as private health insurers, on behalf of patients under care of the organisation, region or central administration mental health services, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (other patient revenue funded expenditure)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Australian dollars. Rounded to the nearest whole dollar.
Collection methods:	Other patient revenue funded expenditure to be reported only once and for the specific statistical unit level at which the expenditure actually occurred e.g. at the State, regional or organisational level. Note: this excludes expenditure funded by Department of Veterans' Affairs payments in respect of specific patients, or funded by the Commonwealth nursing home or hostel subsidies which should be reported in Department of Veterans' Affairs funded expenditure or Commonwealth Government funded expenditure respectively. Where other patient revenue funded expenditure could be allocated to more than one level, it is important to allocate it to the single most appropriate statistical unit level to avoid the possibility of counting the expended funds more than once. For example, funding provided for service delivery expenditure should be reported at the lowest statistical unit level possible only.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: See also Establishment—recurrent expenditure (other revenue funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Implementation in Data Set Specifications: Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure—other recurrent expenditure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (other recurrent expenditure) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270126
Registration status:	Health, Standard 01/03/2005
Definition:	All other recurrent expenditure measured in Australian dollars not included elsewhere in any of the recurrent expenditure categories, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (other recurrent expenditure)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Record values up to hundreds of millions of dollars. Rounded to nearest whole dollar.

Source and reference attributes

Submitting organisation:	National Minimum Data Set Working Parties

Relational attributes

Related metadata references:	Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (community mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure—other revenue funded

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (other revenue funded expenditure), total Australian currency N[N(8)]
METeOR identifier:	288071
Registration status:	Health, Standard 08/12/2004
Definition:	The total recurrent expenditure funded from all other revenue that was received by the organisation, region and central administration and has not been reported elsewhere.
Data Element Concept:	Establishment—recurrent expenditure (other revenue funded expenditure)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Australian dollars. Rounded to nearest whole dollar.
Collection methods:	Expenditure funded from all other revenue, excluding those reported separately, to be reported only once and for the specific statistical unit level at which the expenditure actually occurred e.g. at the State, regional or organisational level. Expenditure reported separately are listed below under the Relational attributes section.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	See also Establishment—recurrent expenditure (state or territory health authority funded), total Australian currency N[N(8)] Health, Standard 08/12/2004 See also Establishment—recurrent expenditure (recoveries funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004 See also Establishment—recurrent expenditure (other state or territory funded expenditure), total Australian currency N[N(8)]

Health, Standard 08/12/2004

See also Establishment—recurrent expenditure (other patient revenue funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Establishment—recurrent expenditure (other Commonwealth Government funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Establishment—recurrent expenditure (National Mental Health Strategy funded), total Australian currency N[N(8)] Health, Standard 08/12/2004

See also Establishment—recurrent expenditure (Department of Veterans' Affairs funded), total Australian currency N[N(8)] Health, Superseded 02/12/2009

Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure—patient transport

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (patient transport cost) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270048
Registration status:	Health, Standard 01/03/2005
Definition:	The direct cost in Australian dollars of transporting patients excluding salaries and wages of transport staff where payment is made by an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (patient transport cost)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Record as currency up to hundreds of millions of dollars. Rounded to nearest whole dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Patient transport, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.7 KB) Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (community mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure—payments to visiting medical officers

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (visiting medical officer payments) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270049
Registration status:	Health, Standard 01/03/2005
Definition:	All payments measured in Australian dollars made by an institutional health care establishment to **visiting medical officers** for medical services provided to hospital (public) patients on an honorary, sessionally paid, or fee for service basis, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (visiting medical officer payments)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Record as currency up to hundreds of millions of dollars. Rounded to nearest whole dollar.
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.

Source and reference attributes

Submitting organisation:	National Minimum Data Set Working Parties

Relational attributes

Related metadata references:	Supersedes Payments to visiting medical officers, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.2 KB) Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is used in the formation of Establishment (mental health) — recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is used in the formation of Establishment (community mental health) — recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health,

Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure—recoveries funded

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (recoveries funded expenditure), total Australian currency N[N(8)]
METeOR identifier:	288685
Registration status:	Health, Standard 08/12/2004
Definition:	Recurrent expenditure funded from revenue that is in the nature of a recovery of expenditure incurred, including income from provision of meals and accommodation, use of facilities, etc. for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (recoveries funded expenditure)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Australian dollars. Rounded to nearest whole dollar.
Collection methods:	Expenditure funded from recoveries to be reported only once and for the specific statistical unit level at which the expenditure actually occurred e.g. at the state, regional or organisational level. Where expenditure funded from recoveries could be allocated to more than one level it is important to allocate it to the single most appropriate statistical unit level to avoid the possible of counting the expended funds more than once. For example, recoveries received through service delivery expenditure should be reported at the lowest statistical unit level possible only.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	See also Establishment—recurrent expenditure (other revenue funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment—recurrent expenditure

(financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure—repairs and maintenance

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (repairs and maintenance) (financial year), total Australian currency N[N(8)]
METeOR identifier:	269970
Registration status:	Health, Standard 01/03/2005
Definition:	The costs in Australian dollars incurred in maintaining, repairing, replacing and providing additional equipment, maintaining and renovating building and minor additional works, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (repairs and maintenance)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Record values up to hundreds of millions of dollars. Rounded to nearest whole dollar. 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).

Source and reference attributes

Submitting organisation:	National Minimum Data Set Working Parties

Relational attributes

Related metadata references:	Supersedes Repairs and maintenance, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB) Is used in the formation of Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is used in the formation of Establishment (community mental health) — recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure—superannuation employer contributions

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (superannuation employer contributions) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270371
Registration status:	Health, Standard 01/03/2005
Definition:	Contributions paid in Australian dollars 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, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (superannuation employer contributions)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Record as currency up to hundreds of millions of dollars. Rounded to nearest whole dollar.
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.

Source and reference attributes

Submitting organisation:	National Minimum Data Set Working Parties

Relational attributes

Related metadata references:

Supersedes Superannuation employer contributions (including funding basis), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.4 KB)

Is used in the formation of Establishment (mental health) — recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is used in the formation of Establishment (community mental health) — recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure—total

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (financial year), total Australian currency N[N(8)]
METeOR identifier:	288993
Registration status:	Health, Standard 08/12/2004
Definition:	Expenditure relating to salaries and wages, non-salary recurrent expenditure and depreciation for a financial year.
Data Element Concept:	Establishment—recurrent expenditure

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Australian dollars. Rounded to nearest whole dollar. Total is calculated from expenditure including: salaries and wages; depreciation; and non-salary recurrent expenditure comprising: 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; and other recurrent expenditure.
Collection methods:	The total grant made to non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding. Can be reported as the total recurrent expenditure if detailed expenditure data are not available.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Is formed using Establishment—recurrent expenditure (visiting medical officer payments) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (patient transport cost) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (other recurrent expenditure) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (other patient revenue funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is formed using Establishment—recurrent expenditure (medical and surgical supplies) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (interest payments) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (food supplies) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (drug supplies) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (domestic services) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (administrative expenses) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (superannuation employer contributions) Health, Standard 01/03/2005

Is formed using Establishment—recurrent expenditure (state or territory health authority funded), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is formed using Establishment—recurrent expenditure (recoveries funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is formed using Establishment—recurrent expenditure (other state or territory funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is formed using Establishment—recurrent expenditure (other revenue funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is formed using Establishment—recurrent expenditure (other Commonwealth Government funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is formed using Establishment (mental health)—recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is formed using Establishment—recurrent expenditure (National

Mental Health Strategy funded), total Australian currency N[N(8)] Health, Standard 08/12/2004

Is formed using Establishment—recurrent expenditure (Department of Veterans' Affairs funded), total Australian currency N[N(8)] Health, Superseded 02/12/2009

Is formed using Establishment—recurrent expenditure (repairs and maintenance) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Referral destination to further care (from specialised mental health residential care)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of residential care—referral destination (mental health care), code N
METeOR identifier:	270130
Registration status:	Health, Standard 01/03/2005
Definition:	The type of health care the **resident** is referred to by the residential mental health care service for further care at the end of residential stay, as represented by a code.
Data Element Concept:	Episode of residential care—referral destination (mental health care)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Specialised mental health admitted patient care
2	Specialised mental health residential care
3	Specialised mental health ambulatory care
4	Private psychiatrist care
5	General practitioner care
6	Other care
7	Not referred
8	Not applicable (i.e. end of reference period)

Supplementary values:

9	Unknown/not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	Where the **resident** is referred to two or more types of health care, the type of health care provided by the service primarily responsible for the care of the resident is to be reported.

Relational attributes

Related metadata references:	Supersedes Referral from specialised mental health residential care, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.5 KB)

Implementation in Data Set Specifications:

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Residential mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Residential mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Referral destination to further care (psychiatric patients)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care (mental health care)—referral destination, code N
METeOR identifier:	269990
Registration status:	Health, Standard 01/03/2005
Definition:	The type of further health service care to which a person is referred from mental health, as represented by a code.
Data Element Concept:	Episode of admitted patient care—referral destination

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
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

Data element attributes

Source and reference attributes

Submitting organisation:	National Minimum Data Set Working Parties

Relational attributes

Related metadata references:	Supersedes Referral to further care (psychiatric patients), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.3 KB)
Implementation in Data Set Specifications:	Admitted patient mental health care NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Referred to ophthalmologist (diabetes mellitus)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—referral to ophthalmologist indicator (last 12 months), code N
METeOR identifier:	302823
Registration status:	Health, Standard 21/09/2005
Definition:	Whether the individual was referred to an **ophthalmologist** within the last 12 months, as represented by a code.
Data Element Concept:	Person—referral to ophthalmologist indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described
	This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes: Record if the individual was referred to an ophthalmologist during the last 12 months.
	CODE 2 No: Record if the individual was not referred to an ophthalmologist during the last 12 months.
Collection methods:	Ask the individual if he/she was referred to an ophthalmologist during the last 12 months. Alternatively, obtain this information from appropriate documentation.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Reference documents: Diabetes Control and Complications Trial: DCCT New England Journal of Medicine, 329(14), September 30, 1993.

Relational attributes

Related metadata references: Supersedes Health service event—referral to ophthalmologist status (last 12 months), code N Health, Superseded 21/09/2005

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Standard 21/09/2005

Region code

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—region identifier, X[X]
METeOR identifier:	269940
Registration status:	Health, Standard 01/03/2005
Definition:	An alphanumeric identifier for the location of health services in a defined geographic or administrative area.
Data Element Concept:	Establishment—region identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	X[X]
Maximum character length:	2

Data element attributes

Collection and usage attributes

Guide for use:	Domain values are specified by individual states/territories. Regions may also be known as Areas or Districts. Any valid region code created by a jurisdiction is permitted.

Relational attributes

Related metadata references:	Supersedes Region code, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.3 KB) Is used in the formation of Establishment—organisation identifier (Australian), NNX[X]NNNNN Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Admitted patient care NMDS Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Community mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Community mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Community mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Community mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Health care client identification Health, Superseded 04/05/2005

Health care client identification DSS Health, Superseded 03/12/2008

Health care client identification DSS Health, Standard 03/12/2008

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Residential mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Residential mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Region of first recurrence

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—region of first recurrence of cancer, code N
METeOR identifier:	289136
Registration status:	Health, Standard 04/06/2004
Definition:	The region of first recurrence of primary cancer after a disease free intermission or remission, as represented by a code.
Data Element Concept:	Person with cancer—region of first recurrence of cancer

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Local
2	Regional
3	Both local and regional
4	Distant
5	Distant and either local or regional
6	Local, regional and distant

Supplementary values:

Value	Meaning
0	None, patient is disease-free
7	Patient was never disease-free
8	Recurred but site unknown
9	Unknown if recurred

Data element attributes

Collection and usage attributes

Guide for use:

The region of the first recurrence following the initial diagnosis should be recorded.

The record should not be updated with subsequent recurrences.

The cancer may recur in more than one site (e.g. both regional and distant metastases).

Record the highest numbered applicable response.

Source and reference attributes

Origin:	Commission on Cancer, American College of Surgeons

Reference documents:	Commission on Cancer, Standards of the Commission on Cancer Volume II Registry Operations and Data Standards (ROADS) (1998)

Relational attributes

Related metadata references:	Supersedes Region of first recurrence, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.0 KB)
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005
	Cancer (clinical) DSS Health, Superseded 06/03/2009
	Cancer (clinical) DSS Health, Superseded 22/12/2009
	Cancer (clinical) DSS Health, Standard 22/12/2009

Regional lymph nodes positive

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—number of positive regional lymph nodes, total N[N]
METeOR identifier:	370027
Registration status:	Health, Standard 06/03/2009
Definition:	The total number of regional lymph nodes reported as containing tumour after examination by a pathologist.
Data Element Concept:	Person with cancer—number of positive regional lymph nodes

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]
Maximum character length:	3

Supplementary values:

Value	Meaning
997	Number of lymph nodes unknown

Data element attributes

Collection and usage attributes

Guide for use:

A list of which lymph nodes are defined as regional lymph nodes for each cancer site may be found in the TNM Classification of Tumours, 6th Edition, UICC.

Number includes all positive nodes regardless of whether removed/examined at a single or multiple procedures, e.g. for breast cancer, record the sum of positive nodes detected in node sampling/sentinel node biopsy and those removed at axillary clearance.

For cancer registries, collection of this data item should only be from notification and pathology reports relating to initial diagnosis and not for recurrent or metastatic disease.

Source and reference attributes

Origin:

Australian Cancer Network

Commission on Cancer American College of Surgeons

Reference documents:

Australian Cancer Network The pathology reporting of breast cancer. A guide for pathologists, surgeons and radiologists Second Edition Sydney (2001)

Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Johnson CH, Adamo M (eds.), SEER Program Coding and Staging Manual 2007. National Cancer Institute, NIH Publication number 07-5581, Bethesda, MD 2007.

Relational attributes

Related metadata references:

Supersedes Person with cancer—number of positive regional lymph nodes, total N[N] Health, Superseded 06/03/2009

See also Person with cancer—number of regional lymph nodes examined, total N[N] Health, Superseded 06/03/2009

Implementation in Data Set Specifications:

Breast cancer (Cancer registries) DSS Health, Standard 06/03/2009

Cancer (clinical) DSS Health, Superseded 22/12/2009

Cancer (clinical) DSS Health, Standard 22/12/2009

Removal date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—waiting list removal date, DDMMYYYY
METeOR identifier:	270082
Registration status:	Health, Standard 01/03/2005
Definition:	Date on which a patient is removed from an elective surgery waiting list.
Data Element Concept:	Elective surgery waiting list episode—waiting list removal date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	This date is recorded when a patient is removed from an elective surgery waiting list. Removal date will be the same as admission date for patients in Reason for removal from elective surgery waiting list categories 1 and 2.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Removal date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB) Is used in the formation of Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Elective surgery waiting times (removals data) NMDS Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2002 *Implementation end date:* 30/06/2006 Elective surgery waiting times (removals data) NMDS 2006-2009 Health, Superseded 03/12/2008 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2009

Elective surgery waiting times (removals data) NMDS 2009-
Health, Standard 03/12/2008

Implementation start date: 01/07/2009

Renal disease therapy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—renal disease therapy, code N
METeOR identifier:	270264
Registration status:	Health, Standard 01/03/2005
Definition:	The therapy the person is receiving for renal disease, as represented by a code.
Data Element Concept:	Person—renal disease therapy

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Drugs for modification of renal disease
2	Drugs for treatment of complications of renal disease
3	Peritoneal dialysis
4	Haemodialysis
5	Functioning renal transplant

Collection and usage attributes

Guide for use:

CODE 1 Drugs for modification of renal disease

This code is used to indicate drugs for modification of renal disease, includes drugs intended to slow progression of renal failure. Examples include antiproteinurics such as angiotensin converting enzyme inhibitors (ACEI), angiotensin II receptor antagonists (ATRA) and immunosuppressants.

CODE 2 Drugs for treatment of complications of renal disease

This code is used to indicate drugs for the treatment of the complications of renal disease. Examples include antihypertensive agents and drugs that are intended to correct biochemical imbalances caused by renal disease (e.g. loop diuretics, ACEI, erythropoietin, calcitriol, etc).

CODE 3 Peritoneal dialysis

This code is used to indicate peritoneal dialysis, chronic peritoneal dialysis, delivered at home, at a dialysis satellite centre or in hospital.

CODE 4 Haemodialysis

This code is used to indicate haemodialysis, chronic

haemodialysis delivered at home, at a dialysis satellite centre or in hospital.

CODE 5 Functioning renal transplant

This code is used to indicate functioning renal transplant, the presence of a functioning renal transplant.

Data element attributes

Collection and usage attributes

Guide for use: More than one code can be recorded.

Collection methods: To be collected on commencement of treatment and regularly reviewed.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Origin: Caring for Australians with Renal Impairment Guidelines. Australian Kidney Foundation

Relational attributes

Related metadata references: Supersedes Renal disease therapy, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.5 KB)

Implementation in Data Set Specifications: Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Renal disease—end-stage (diabetes complication)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—end-stage renal disease status (diabetes complication), code N
METeOR identifier:	270373
Registration status:	Health, Standard 01/03/2005
Definition:	Whether an individual has end-stage renal disease as a complication of diabetes, and has required dialysis or has undergone a kidney transplant, as represented by a code.
Data Element Concept:	Person—end-stage renal disease status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	End-stage renal disease - developed in the last 12 months
2	End-stage renal disease - developed prior to the last 12 months
3	No end-stage of renal disease

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Collection methods:	Ask the individual if he/she has required dialysis or has undergone a kidney (renal) transplant (due to diabetic nephropathy). Alternatively obtain the relevant information from appropriate documentation.

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:	Supersedes Renal disease - end stage, diabetes complication, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.9 KB)

Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Superseded 21/09/2005 Diabetes (clinical) DSS Health, Standard 21/09/2005

Residential stay start date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Residential stay—episode start date, DDMMYYYY
METeOR identifier:	269953
Registration status:	Health, Standard 01/03/2005
Definition:	Date on which a **resident** formally started a residential stay.
Data Element Concept:	Residential stay—episode start date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Relational attributes

Related metadata references: Supersedes Residential stay start date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.6 KB)

Implementation in Data Set Specifications:

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Residential mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Residential mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Residual expenditure (mental health service)—Mental Health Act Regulation or related legislation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—residual expenditure (Mental Health Act Regulation or related legislation), total Australian currency N[N(8)]
METeOR identifier:	376828
Registration status:	Health, Standard 02/12/2009
Definition:	Total residual expenditure measured in Australian dollars incurred in the establishment and operation of Mental Health Act review bodies.
Data Element Concept:	Specialised mental health service—residual expenditure (Mental Health Act Regulation or related legislation)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.
Collection methods:	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level. Report Mental Health Act Regulation or related legislation expenditure only where the activity occurred independently to service units and where that expenditure is not reported elsewhere. Where the Mental Health Act Regulation or related legislation activity occurs as an integral component of service delivery (e.g. in cases where the service is already reporting activity data), the expenditure should be reported under the relevant service unit.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Residual expenditure (mental health service)—academic positions

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—residual expenditure (academic positions), total Australian currency N[N(8)]
METeOR identifier:	290151
Registration status:	Health, Standard 08/12/2004
Definition:	Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). Academic positions refer to grants from the organisation, region or state/territory administration to academic institutions for the establishment and maintenance of academic positions in psychiatry or related disciplines. This item also includes the costs of the other academic positions associated with the professional position where these are financed from within the organisation, region or central administration's recurrent budget.
Data Element Concept:	Specialised mental health service—residual expenditure (academic positions)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants. This item also includes the costs of the other academic positions associated with the professional position where these are financed from within the organisation, region or central administration's recurrent budget.

Collection methods:

Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level. Expenditure should be reported for these categories, where applicable:

- Report academic expenditure in this section only where the academic unit operates independently. Where the academic unit or position operates as an integral part of the service (e.g. an acute inpatient unit), the expenditure should be reported for the relevant organisation.
- Where academic grants are paid directly by organisation, region or state/territory administration, these should be reported at that level.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Residual expenditure (mental health service)—education and training

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—residual expenditure (education and training), total Australian currency N[N(8)]
METeOR identifier:	290149
Registration status:	Health, Standard 08/12/2004
Definition:	Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). Education and training refers to the cost of professional training and staff development activity within the mental health services managed by the organisation, region or state/territory administration that have not been included in expenditure reported elsewhere.
Data Element Concept:	Specialised mental health service—residual expenditure (education and training)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants. Grants made to external agencies for the development of training-related resources materials or programs may also be reported under this category.
Collection methods:	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one

level. Expenditure should be reported for these categories, where applicable.

Where they do exist, expenditure on schools of nursing should be reported at the organisation level.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Residual expenditure (mental health service)—insurance

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—residual expenditure (insurance), total Australian currency N[N(8)]
METeOR identifier:	290164
Registration status:	Health, Standard 08/12/2004
Definition:	Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). Insurance refers to public risk and other insurance amounts paid by the organisation, region or central administration in respect to its mental health services and not reported elsewhere.
Data Element Concept:	Specialised mental health service—residual expenditure (insurance)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.
Collection methods:	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level. Expenditure should be reported for these categories, where applicable. Note: insurance expenditure already included in an establishment's expenditure should not be included in this data element.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Residual expenditure (mental health service)—mental health promotion

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—residual expenditure (mental health promotion), total Australian currency N[N(8)]
METeOR identifier:	290156
Registration status:	Health, Standard 08/12/2004
Definition:	Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). It refers to the organisation, region or state/territory administration expenditure dedicated specifically to mental health promotion objectives. Mental health promotion is defined as activities designed to lead to improvement of the mental health functioning of persons through prevention, education and intervention activities and services.
Data Element Concept:	Specialised mental health service—residual expenditure (mental health promotion)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants. Reporting expenditure against this item is not intended to be based on costing of activities that retrospectively, entailed a significant mental health promotion component. Instead it should be confined to financial allocations that were clearly targeted towards mental health promotion objectives.

Collection methods:

Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level.

Do not count these costs if they have been included in the expenditure reported by service delivery organisations within the region.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Residual expenditure (mental health service)—mental health research

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—residual expenditure (mental health research), total Australian currency N[N(8)]
METeOR identifier:	290153
Registration status:	Health, Standard 08/12/2004
Definition:	Expenditures by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). It refers to expenditure on basic or applied research in the mental health field funded by the organisation, region or state/territory administration.
Data Element Concept:	Specialised mental health service—residual expenditure (mental health research)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.
Collection methods:	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level. Expenditure should be reported for these categories, where applicable: Report research expenditure for this category only where the research operated independently and where that expenditure is not reported elsewhere. Where the research activity occurs as an integral component of service delivery (e.g. in cases where

research staff are also clinical staff within a hospital unit), the expenditure should be reported under the relevant service unit (at the organisation-level).

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Residual expenditure (mental health service)—other indirect expenditure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—residual expenditure (other indirect expenditure), total Australian currency N[N(8)]
METeOR identifier:	290187
Registration status:	Health, Standard 08/12/2004
Definition:	Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). Includes any other indirect expenditure (excluding grants to non-government organisations to provide mental health services other than residential services) that is incurred in the delivery of mental health services and is not reported elsewhere.
Data Element Concept:	Specialised mental health service—residual expenditure (other indirect expenditure)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.
Collection methods:	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Residual expenditure (mental health service)—patient transport services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—residual expenditure (patient transport services), total Australian currency N[N(8)]
METeOR identifier:	290183
Registration status:	Health, Standard 08/12/2004
Definition:	Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). It refers to direct cost of transporting patients of mental health services.
Data Element Concept:	Specialised mental health service—residual expenditure (patient transport services)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.
Collection methods:	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level.

Relational attributes

Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Residual expenditure (mental health service)—program administration

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—residual expenditure (program administration), total Australian currency N[N(8)]
METeOR identifier:	290145
Registration status:	Health, Standard 08/12/2004
Definition:	Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). It refers to costs of administration and other support services (such as program management, admissions reception office, medical records etc.) at the mental health program-level (i.e. at state or territory, region or organisation level). Generally, these are resources that are specifically dedicated to the mental health program, are under the direct management control of the program and are funded by the program.
Data Element Concept:	Specialised mental health service—residual expenditure (program administration)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Generally, these are resources that are specifically dedicated to the mental health program, are under the direct management control of the program and are funded by the program. Excludes grants to non-government organisations for services that are to be reported separately. These include grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.

Collection methods:

Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level. Expenditure should be reported for these categories, where applicable:

Do not count these costs if they have been included in the expenditure reported by service delivery organisations within the region.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Residual expenditure (mental health service)—property leasing costs

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—residual expenditure (property leasing costs), total Australian currency N[N(8)]
METeOR identifier:	290185
Registration status:	Health, Standard 08/12/2004
Definition:	Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). It refers to the costs of leasing premises used for the provision of mental health services (e.g. community clinics).
Data Element Concept:	Specialised mental health service—residual expenditure (property leasing costs)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.
Collection methods:	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level.

Relational attributes

Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Residual expenditure (mental health service)—service development

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—residual expenditure (service development), total Australian currency N[N(8)]
METeOR identifier:	373040
Registration status:	Health, Standard 02/12/2009
Definition:	Residual expenditure measured in Australian dollars relating to the development of new mental health services funded by the organisation, region or state/territory administration that are not yet operational and providing activity data.
Data Element Concept:	Specialised mental health service—residual expenditure (service development)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants. Residual expenditures by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit).
Collection methods:	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level. Expenditure should be reported for these categories, where applicable.

Report service development expenditure only where the service development operates independently and where that expenditure is not reported elsewhere. Where the service development activity occurs as an integral component of service delivery (e.g. in cases where the service is already reporting activity data), the expenditure should be reported under the relevant service unit.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Residual expenditure (mental health service)—superannuation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—residual expenditure (superannuation), total Australian currency N[N(8)]
METeOR identifier:	290158
Registration status:	Health, Standard 08/12/2004
Definition:	Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). It includes superannuation employer contributions paid, or for an emerging cost scheme, that should be paid on behalf of the employee and that are not reported elsewhere. 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.
Data Element Concept:	Specialised mental health service—residual expenditure (superannuation)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.
Collection methods:	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level. Expenditure should be reported for these categories, where applicable.

Note: Superannuation expenditure already included in establishments expenditure should not be included in this data element.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Residual expenditure (mental health service)—support services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—residual expenditure (support services), total Australian currency N[N(8)]
METeOR identifier:	290147
Registration status:	Health, Standard 08/12/2004
Definition:	Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). It refers to the cost of administration and other support services provided at the region-level. Such services include regional administration, information systems, personnel, finance and accounting functions. These services are usually provided from a central pool of resources managed at a regional level.
Data Element Concept:	Specialised mental health service—residual expenditure (support services)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.
Collection methods:	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level. Expenditure should be reported for these categories, where applicable: These services are usually provided from a central pool of

resources managed at a regional level. Do not count these costs if they have been included in the expenditure reported by service delivery organisations within the region.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Residual expenditure (mental health service)—workers compensation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—residual expenditure (workers compensation), total Australian currency N[N(8)]
METeOR identifier:	290160
Registration status:	Health, Standard 08/12/2004
Definition:	Expenditures in Australian dollars specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). It refers to workers compensation premiums and payments made by the organisation, region or central administration on behalf of its employees and not reported elsewhere.
Data Element Concept:	Specialised mental health service—residual expenditure (workers compensation)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.
Collection methods:	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level. Note: Workers compensation expenditure already included in establishments expenditure should not be included in this data element.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Resuscitation of baby—method

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—baby resuscitation method, code N
METeOR identifier:	270116
Registration status:	Health, Standard 01/03/2005
Definition:	Active measures taken immediately after birth to establish independent respiration and heartbeat, or to treat depressed respiratory effect and to correct metabolic disturbances, as represented by a code.
Data Element Concept:	Birth event—baby resuscitation method

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
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

Supplementary values:

Value	Meaning
9	Not stated

Collection and usage attributes

Guide for use: CODE 3 Oxygen therapy only

If oxygen is given by bag and mask without IPPR, code as 'oxygen therapy'.

Data element attributes

Collection and usage attributes

Guide for use: This metadata item does not include drug therapy.

Code the most severe measure used.

Comments: Required to analyse need for resuscitation after complications of labour and delivery and to evaluate level of services needed for different birth settings.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Resuscitation of baby, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.6 KB)

Retirement status in registered profession

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—retirement status in registered profession, code N
METeOR identifier:	383426
Registration status:	Health, Standard 10/12/2009
Definition:	Whether a registered health professional is retired from their registered profession, as represented by a code.
Data Element Concept:	Registered health professional—retirement status in registered profession

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Retired
2	Not retired

Supplementary values:

9	Unknown/inadequately described

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Reference documents:	Retirement and Retirement Intentions, Australia, Jul 2006 to Jun 2007 (ABS Cat. no. 6238.0)

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 RETIRED

This category includes persons who have retired from working or looking for work in the registered profession, and who do not intend to look for or take up work in the registered profession in the future. This definition is based on the ABS definition of 'retired from the labour force', as used in the ABS Retirement and Retirement Intentions survey.

CODE 2 NOT RETIRED

All persons who are not 'retired' as defined above.

Data is self-reported based on the retirement status in the registered profession in the week before registration.

The data element is only applicable to health professionals who are not employed in the registered profession in Australia.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Labour force status cluster Health, Standard 10/12/2009

Revenue—other

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—revenue (other revenue) (financial year), total Australian currency N[N(8)]
METeOR identifier:	364799
Registration status:	Health, Standard 05/12/2007
Definition:	All other revenue measured in Australian dollars received by the establishment for a financial year, that is not included under patient revenue or recoveries (but not including revenue payments received from State or Territory governments).
Data Element Concept:	Establishment—revenue (other revenue)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Record as currency up to hundreds of millions of dollars. Rounded to the nearest whole dollar.

Relational attributes

Related metadata references:	Supersedes Establishment—revenue (other revenue) (financial year), total Australian currency N[N(8)] Health, Superseded 05/12/2007
Implementation in Data Set Specifications:	Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008 *Implementation start date:* 01/07/2008 *Implementation end date:* 30/06/2009 Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010 *Implementation start date:* 01/07/2009 Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010 *Implementation start date:* 01/07/2010

Revenue—patient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—revenue (patient) (financial year), total Australian currency N[N(8)]
METeOR identifier:	364797
Registration status:	Health, Standard 05/12/2007
Definition:	All revenue measured in Australian dollars for a financial year, received by, and due to, an establishment in respect of individual patient liability for accommodation and other establishment charges.
Data Element Concept:	Establishment—revenue (patient)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Record as currency up to hundreds of millions of dollars. Rounded to nearest whole dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Establishment—revenue (patient) (financial year), total Australian currency N[N(8)] Health, Superseded 05/12/2007
Implementation in Data Set Specifications:	Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008 *Implementation start date:* 01/07/2008 *Implementation end date:* 30/06/2009 Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010 *Implementation start date:* 01/07/2009 Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010 *Implementation start date:* 01/07/2010

Revenue—recoveries

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—revenue (recoveries) (financial year), total Australian currency N[N(8)]
METeOR identifier:	364805
Registration status:	Health, Standard 05/12/2007
Definition:	All revenue received in Australian dollars for a financial year, that is in the nature of a recovery of expenditure incurred.
Data Element Concept:	Establishment—revenue (recoveries)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Record as currency up to hundreds of millions of dollars. Rounded to nearest whole dollar. This metadata item relates to all revenue received by establishments except for general revenue payments received from state or territory governments.
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.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Establishment—revenue (recoveries) (financial year), total Australian currency N[N(8)] Health, Superseded 05/12/2007

Implementation in Data Set Specifications:

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Satisfaction with participation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—level of satisfaction with participation in a life area, code N
METeOR identifier:	320216
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The degree to which a person is satisfied with their involvement in a specified life area, as represented by a code.
Context:	Human functioning and disability
Data Element Concept:	Person—level of satisfaction with participation in a life area

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values: / *Supplementary values:*

Value	Meaning
0	High satisfaction with participation
1	Moderate satisfaction with participation
2	Neither satisfied nor dissatisfied with participation
3	Moderate dissatisfaction with participation
4	Extreme dissatisfaction with participation
5	Complete restriction and dissatisfaction
8	Not specified
9	Not applicable

Collection and usage attributes

Guide for use:

This metadata item contributes to the definition of the concept '**Disability**' and gives an indication of the experience of disability for a person.

In the context of health, participation is involvement in a life situation. Participation restrictions are problems an individual may experience in involvement in life situations.

This metadata item gives a rating of the person's degree of satisfaction with participation in a domain of life, in relation to their current life goals. Satisfaction with participation corresponds to the person's own perspective on their participation, and reflects their attitude to their participation in the various life areas. It is essentially a summary measure in

which are embedded the concepts of choice, opportunity and importance.

CODE 0 High satisfaction with participation

Used if a person is involved in the specified life situation as he or she wishes to fulfil his or her current life goals in terms of duration, frequency, manner and outcome.

CODE 1 Moderate satisfaction with participation

Used if the person is reasonably satisfied with their participation in this life situation, in terms of duration, frequency, manner and outcome. This could occur if one of the criteria (duration, frequency, manner or outcome) is not fulfilled and that criterion is not critical to the person's goals. For example, the person does not participate in the specified life situation as frequently as wished, but the other criteria are met and the frequency is not so affected that it is critical to the person's satisfaction.

CODE 2 Neither satisfied nor dissatisfied with participation

Used if the person is neither satisfied nor dissatisfied with their participation in this life situation, in terms of duration, frequency, manner and outcome.

CODE 3 Moderate dissatisfaction with participation

Used if two or three criteria (duration, frequency, manner or outcome) are not fulfilled, but are not so badly affected, in relation to the person's goals in that life area, that the person is extremely dissatisfied. For example, a person is able to participate in work, but is placed in supported employment rather than employment in the open labour market. This is not in line with the person's goals, so that the manner and outcome of the participation are not fulfilled.

CODE 4 Extreme dissatisfaction with participation

Used when all criteria (duration, frequency, manner and outcome) are not fulfilled for the specified life situation, or where any of the criteria are so badly affected in relation to the person's goals that they consider themselves to be extremely dissatisfied with this life area. An example of the latter would arise when a person is extremely dissatisfied with participation in interpersonal activities because his/her goal in terms of duration of social visits is never fulfilled, although other criteria (frequency and manner) may be fulfilled.

CODE 5 Complete restriction and dissatisfaction

Used when the person does not participate in this life situation in line with his or her own goals, i.e. in an area where they wish to participate and is completely dissatisfied with not participating in this life situation.

CODE 9 Not applicable

Used when participation in a life situation is not relevant, such as employment of an infant or where there is no participation and the person has no desire to participate in this area. For example, a personal preference not to participate in specific areas of community, social and civic life such as sport or hobbies. The area may not be applicable to the person's current life goals.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin: WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents: Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website http://www.who.int/classifications/icf/en/
- Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.cfm

Data element attributes

Collection and usage attributes

Guide for use: Satisfaction with participation should be coded from the perspective of the person. This data element should be coded in conjunction with the Person—activities and participation life area, code (ICF 2001) AN[NNN] data element. For example, a person's 'moderate satisfaction with participation in exchange of information'.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references: See also Person—activity and participation life area, code (ICF 2001) AN[NNN] Health, Standard 29/11/2006, Community services, Standard 16/10/2006

Implementation in Data Set Specifications: Activities and Participation cluster Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Scheduled admission date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Admitted patient care waiting list episode—scheduled admission date, DDMMYYYY
METeOR identifier:	269978
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which it is proposed that a patient on the waiting list will be admitted for an episode of care.
Data Element Concept:	Admitted patient care waiting list episode—scheduled admission date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Comments:	If this metadata item 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). This metadata item is required for the purposes of hospital management - allocation of beds, operating theatre time and other resources.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Scheduled admission date, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.5 KB)

Separation date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—separation date, DDMMYYYY
METeOR identifier:	270025
Registration status:	Health, Standard 01/03/2005
Definition:	Date on which an admitted patient completes an episode of care.
Data Element Concept:	Episode of admitted patient care—separation date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

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.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Separation date, version 5, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.2 KB)

Is used in the formation of Establishment—number of separations (financial year), total N[NNNNN] Health, Standard 01/03/2005

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v 6) NN Health, Standard 22/12/2009

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v 6) ANNA Health, Standard 22/12/2009

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA Health, Superseded 22/12/2009

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN Health, Superseded 22/12/2009

Is used in the formation of Episode of admitted patient care—length of stay (including leave days), total N[NN] Health, Standard 04/07/2007

Is used in the formation of Episode of admitted patient care—length of stay (including leave days) (postnatal), total N[NN] Health, Standard 04/07/2007

Is used in the formation of Episode of admitted patient care—length of stay (excluding leave days), total N[NN] Health, Standard 01/03/2005

Is used in the formation of Episode of care—number of psychiatric care days, total N[NNNN] Health, Standard 01/03/2005

Is used in the formation of Episode of admitted patient care—length of stay (including leave days), total N[NN] Health, Superseded 04/07/2007

Is used in the formation of Episode of admitted patient care (postnatal)—length of stay (including leave days), total N[NN] Health, Superseded 04/07/2007

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Admitted patient palliative care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient palliative care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient palliative care NMDS 2007-08 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient palliative care NMDS 2008-09 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient palliative care NMDS 2009-10 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient palliative care NMDS 2010-11 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Perinatal NMDS Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Perinatal NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Perinatal NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Separation time

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—separation time, hhmm
METeOR identifier:	270026
Registration status:	Health, Standard 01/03/2005
Definition:	Time at which an admitted patient completes an episode of care.
Data Element Concept:	Episode of admitted patient care—separation time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Comments:	Required to identify the time of completion of the episode or hospital stay, for calculation of length of stay.

Relational attributes

Related metadata references:	Supersedes Separation time, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (13.3 KB)

Separations

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of separations (financial year), total N[NNNNN]
Synonymous names:	Discharge
METeOR identifier:	270407
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of **separations** occurring during the reference period. This includes both formal and statistical separations.
Data Element Concept:	Establishment—number of separations

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Separation

Data element attributes

Collection and usage attributes

Guide for use:

May be calculated at:

- individual establishment level; or
- system (i.e. state/territory) level i.e. the sum of the number of establishments.

The sum of the number of separations where the separation date has a value:

- >= the beginning of the reference period (typically a financial year); and
- <= the end of the reference period.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Is formed using Episode of admitted patient care—separation date, DDMMYYYY Health, Standard 01/03/2005

Supersedes Separations, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.3 KB)

Implementation in Data Set Specifications:

Community mental health establishments NMDS 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Service contact date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service contact—service contact date, DDMMYYYY
METeOR identifier:	270122
Registration status:	Health, Standard 01/03/2005
Definition:	The date of service contact between a health service provider and patient/client.
Data Element Concept:	Service contact—service contact date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

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.

Relational attributes

Related metadata references:	Supersedes Service contact date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB) Is used in the formation of Person—number of service contact dates, total N[NN] Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006 Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007 Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009 Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Community mental health care 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Service mode (non-admitted patient)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient service event—service mode, hospital code N{.N}
METeOR identifier:	270096
Registration status:	Health, Standard 01/03/2005
Definition:	Relative physical location of the patient, provider and the hospital campus of the provider of a non-admitted patient service event, as represented by a code.
Data Element Concept:	Non-admitted patient service event—service mode

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N{.N}
Maximum character length:	2

Permissible values:

Value	Meaning
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

Collection and usage attributes

Guide for use:

CODE 1.1 On the hospital campus of the provider

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.

CODE 1.2 Not on the hospital campus of the provider

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.

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Non-admitted patient service mode, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.8 KB)

Service type (non-admitted patient)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient service event—service event type (clinical), code N[N]
METeOR identifier:	270090
Registration status:	Health, Standard 01/03/2005
Definition:	The type of clinical service provided to a non-admitted patient in a non-admitted patient service event, as represented by a code.
Data Element Concept:	Non-admitted patient service event—service event type (clinical)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
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

Collection and usage attributes

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 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
Pathology	Pathology
Paediatrics	Adolescent health Neonatal Paediatric medicine Paediatric surgery
Pharmacy	Dispensing pharmacy
Psychiatric	Psychiatry
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.

Data element attributes

Relational attributes

Related metadata references:

Supersedes Non-admitted patient service type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (25.1 KB)

Sex

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—sex, code N
METeOR identifier:	287316
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 10/02/2006
Definition:	The biological distinction between male and female, as represented by a code.
Data Element Concept:	Person—sex

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Male
2	Female
3	Intersex or indeterminate

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Diagnosis and procedure codes should be checked against the national ICD-10-AM sex edits, unless the person is undergoing, or has undergone a sex change or has a genetic condition resulting in a conflict between sex and ICD-10-AM code.

CODE 3 Intersex or indeterminate

Intersex or indeterminate, refers to a person, who because of a genetic condition, was born with reproductive organs or sex chromosomes that are not exclusively male or female or whose sex has not yet been determined for whatever reason.

Intersex or indeterminate, should be confirmed if reported for people aged 90 days or greater.

Comments:

The definition for Intersex in Guide for use is sourced from the ACT Legislation (Gay, Lesbian and Transgender) Amendment Act 2003.

Source and reference attributes

Origin:

Australian Capital Territory 2003. Legislation (Gay, Lesbian and Transgender) Amendment Act 2003

Reference documents: Legislation (Gay, Lesbian and Transgender) Amendment Act 2003. See http://www.legislation.act.gov.au/a/2003-14/20030328-4969/pdf/2003-14.pdf.

Data element attributes

Collection and usage attributes

Collection methods:

Operationally, sex is the distinction between male and female, as reported by a person or as determined by an interviewer.

When collecting data on sex by personal interview, asking the sex of the respondent is usually unnecessary and may be inappropriate, or even offensive. It is usually a simple matter to infer the sex of the respondent through observation, or from other cues such as the relationship of the person(s) accompanying the respondent, or first name. The interviewer may ask whether persons not present at the interview are male or female.

A person's sex may change during their lifetime as a result of procedures known alternatively as sex change, gender reassignment, transsexual surgery, transgender reassignment or sexual reassignment. Throughout this process, which may be over a considerable period of time, the person's sex could be recorded as either Male or Female.

In data collections that use the ICD-10-AM classification, where sex change is the reason for admission, diagnoses should include the appropriate ICD-10-AM code(s) that clearly identify that the person is undergoing such a process. This code(s) would also be applicable after the person has completed such a process, if they have a procedure involving an organ(s) specific to their previous sex (e.g. where the patient has prostate or ovarian cancer).

CODE 3 Intersex or indeterminate

Is normally used for babies for whom sex has not been determined for whatever reason.

Should not generally be used on data collection forms completed by the respondent.

Should only be used if the person or respondent volunteers that the person is intersex or where it otherwise becomes clear during the collection process that the individual is neither male nor female.

CODE 9 Not stated/inadequately described

Is not to be used on primary collection forms. It is primarily for use in administrative collections when transferring data from data sets where the item has not been collected.

Source and reference attributes

Origin: Australian Institute of Health and Welfare (AIHW) National Mortality Database 1997/98 AIHW 2001 National Diabetes Register, Statistical Profile, December 2000 (Diabetes Series No. 2.)

Reference documents:

Australian Bureau of Statistics

AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia

In AS4846 and AS5017 alternative codes are presented. Refer to the current standard for more details.

Relational attributes

Related metadata references:

Supersedes Person—sex, code N Health, Superseded 04/05/2005, Community services, Superseded 31/08/2005

Is used in the formation of Record—linkage key, code 581 XXXXXDDMMYYYYN Community services, Standard 21/05/2010

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v 6) NN Health, Standard 22/12/2009

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v 6) ANNA Health, Standard 22/12/2009

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA Health, Superseded 22/12/2009

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN Health, Superseded 22/12/2009

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Admitted patient palliative care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient palliative care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient palliative care NMDS 2007-08 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient palliative care NMDS 2008-09 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient palliative care NMDS 2009-10 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient palliative care NMDS 2010-11 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Alcohol and other drug treatment services NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Superseded 06/03/2009

Cancer (clinical) DSS Health, Superseded 22/12/2009

Cancer (clinical) DSS Health, Standard 22/12/2009

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Community mental health care 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Community mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Community mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Community mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Community mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Computer Assisted Telephone Interview demographic module DSS Health, Superseded 03/12/2008

Computer Assisted Telephone Interview demographic module DSS Health, Standard 03/12/2008

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Health care client identification DSS Health, Superseded 03/12/2008

Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Superseded 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Non-admitted patient emergency department care NMDS

Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Non-admitted patient emergency department care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Perinatal NMDS Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Perinatal NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Perinatal NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Registered chiropractic labour force DSS Health, Standard 10/12/2009

Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009

Registered medical professional labour force DSS Health, Standard 10/12/2009

Registered midwifery labour force DSS Health, Standard 10/12/2009

Registered nursing professional labour force DSS Health, Standard 10/12/2009

Registered optometry labour force DSS Health, Standard 10/12/2009

Registered osteopathy labour force DSS Health, Standard 10/12/2009

Registered pharmacy labour force DSS Health, Standard 10/12/2009

Registered physiotherapy labour force DSS Health, Standard 10/12/2009

Registered podiatry labour force DSS Health, Standard 10/12/2009

Registered psychology labour force DSS Health, Standard 10/12/2009

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Residential mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Residential mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Source of public and private revenue

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health industry relevant organisation—source of revenue, public and private code NNN
METeOR identifier:	352427
Registration status:	Health, Standard 05/12/2007
Definition:	The source of revenue received by a health industry relevant organisation, as represented by a code.
Data Element Concept:	Health industry relevant organisation—source of revenue

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NNN
Maximum character length:	3

Permissible values:

Value	Meaning
	Public sector
101	Australian Health Care Agreements
102	Other Special Purpose Payments
103	Medicare
104	Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme
105	National Health and Medical Research Council
106	Department of Veterans' Affairs
107	Other Australian government departments
108	State/Territory non-health departments
188	Other public sector revenue
	Private sector
201	Private health insurance
202	Workers compensation insurance
203	Motor vehicle third party insurance
204	Other compensation (e.g. Public liability, common law, medical negligence)
205	Private households (self-funded and out-of-pocket expenditure)
206	Non-profit institutions serving households
207	Corporations (other than health insurance)
288	Other private sector revenue

301	Overseas
999	Not further defined

Collection and usage attributes

Guide for use:

Public sector

CODE 101 Australian Health Care Agreements

This item is not currently required to be reported by state or territory health authorities.

Revenue received from the Australian Government Department of Health and Ageing under the Australian Health Care Agreements to assist in the cost of providing public patients with free access to public hospital services within a clinically appropriate time irrespective of where patients live.

CODE 102 Other Special Purpose Payments

This item is not currently required to be reported by state or territory health authorities.

Includes Specific Purpose Payments provided by the Australian Government to the states and territories such as:

- Public Health Outcomes Funding Agreement grants
- Highly Specialised Drugs grants
- National Radiotherapy grants
- National Mental Health Information Development grant
- Magnetic Resonance Imaging grants
- Postgraduate Medical Training grants
- Hepatitis C Education and Prevention grant
- Royal Flying Doctor Service grants

Excludes AHCA grants, Medicare or PBS/RPBS payments.

CODE 103 Medicare

This item is not currently required to be reported by state or territory health authorities.

Includes revenue received for services listed in the Medical Benefits Schedule that are provided by registered medical practitioners. Many medical services in Australia are provided on a fee-for-service basis and attract benefits or revenue from the Australian Government under Medicare.

Includes revenue received for medical services provided to private admitted patients in hospitals as well as some revenue that is not based on fee-for-service (i.e. alternative funding arrangements).

CODE 104 Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceuticals Benefits Scheme (RPBS)

Includes pharmaceuticals in the PBS and RPBS for which the Australian Government paid a benefit.

Excludes:

- revenue received for pharmaceuticals for which no PBS or RPBS benefit was paid;

- revenue received for other non-pharmaceutical medications;
- pharmaceuticals listed in the PBS or RPBS, the total costs of which are equal to, or less than, the statutory patient contribution for the class of patient concerned;
- medicines dispensed through private prescriptions that do not fulfil the criteria for payment under the PBS or RPBS; and
- over-the-counter medicines such as pharmacy-only medicines, aspirin, cough and cold medicines, vitamins and minerals, herbal and other complementary medicines, and a range of medical non-durables, such as bandages, band aids and condoms.

CODE 105 National Health and Medical Research Council

Includes health research funded by the National Health and Medical Research Council that is not reported elsewhere.

CODE 106 Department of Veterans' Affairs

Includes revenues received for health services provided to veterans, war widows and widowers with gold or white DVA cards. Types of services include public and private hospitals, local medical officers and specialists, residential aged care subsidy, allied health, rehabilitation appliances, dental services, community nursing, Veterans' Home Care and travel for treatment.

Excludes revenues received for pharmaceuticals provided to veterans, war widows and widowers with gold, white or orange DVA cards which are reported under code 104.

CODE 107 Other Australian Government Departments

Includes other revenues received for health services from, for example, the Department of Immigration and Citizenship and Department of Defence. Excludes Medicare payments from Medicare Australia (part of Department of Human Services) reported under code 103.

CODE 108 State/Territory non-health Departments

Includes correctional facilities, and departments that have contributed funding for the provision of a health service e.g. public health, emergency services, NSW Food Authority, NSW Health Care Complaints Commission, South Australia Ambulance Service, National Blood Authority, Red Cross, and prison health services such as WA Health services directorate and St Vincent's Correctional Health Service Victoria.

CODE 188 Other public sector revenue

Includes all public sector revenue other than those reported under codes 101 to 108. May include revenue from Local governments.

Private sector

CODE 201 Private health insurance

Includes revenue from businesses mainly engaged in providing insurance cover for hospital, medical, dental or pharmaceutical expenses or costs.

Excludes:

1. accident and sickness insurance

2. liability insurance
3. life insurance
4. general insurance
5. other insurance business excluded by the Private Health Insurance (Health Insurance Business) Rules
6. overseas visitors for whom travel insurance is the major funding source.

State and territory health authorities may report revenues for admitted patients, from private health insurance funds and private households, as a combined total if these revenues are not able to be reported separately.

CODE 202 Workers compensation insurance

Includes benefits paid under workers compensation insurance to the health industry relevant organisation for health care provided to workers, including trainees and apprentices, who have experienced a work-related injury. Type of benefits includes fees for medical or related treatment.

Excludes benefits paid under public liability, common law or medical negligence.

CODE 203 Motor vehicle third party insurance

Includes personal injury claims arising from motor accidents and compensation for accident victims and their families for injuries or death. Excludes benefits paid under workers compensation insurance, public liability, common law or medical negligence.

CODE 204 Other compensation (e.g. Public liability, common law, medical negligence).

This item is not currently required to be reported by state or territory health authorities.

Includes revenues received from:

- public liability insurance for injury arising from an incident related to the organisation's normal activities;
- a court-ordered settlement for damages because of negligence under specific conditions a duty of care exists and was breached and material damage resulted as a consequence;
- health professionals employed by health authorities or otherwise covered by health authority professional indemnity arrangements; and
- a common law settlement cancels all other entitlements to workers compensation benefits. If a common law claim is not successful, the worker will continue to receive workers compensation under the statutory scheme.

Excludes benefits paid under motor vehicle third party insurance.

CODE 205 Private households (self-funded and out-of-pocket expenditure)

Includes payments received from the patient, the patient's family or friends, or other benefactors (i.e. patient revenue).

Includes cost-sharing and informal payments to health care

providers. Cost-sharing is a provision of health insurance or third-party payment that requires the individual who is covered to pay part of the cost of health care received. This is distinct from the payment of a health insurance premium, contribution or tax which is paid whether health care is received or not.

Cost-sharing can be in the form of co-payments, co-insurance or deductibles:

- co-payment: cost-sharing in the form of a fixed amount to be paid for a service;
- co-insurance: cost-sharing in the form of a set proportion of the cost of a service; and
- deductibles: cost-sharing in the form of a fixed amount which must be paid for a service before any payment of benefits can take place.

CODE 206 Non-profit institutions serving households

Non-profit institutions serving households (NPISHs) (i.e. non-profit NGOs) consist of non-profit institutions which provide goods or services to households free or at prices that are not economically significant. Such NPISHs may provide health care goods or services on a non-market basis to households in need, including households affected by natural disasters or war.

The revenues received from such NPISHs are provided mainly by donations in cash or in kind from the general public, corporations or governments. These include organisations such as the National Heart Foundation, Diabetes Australia or the Cancer Council etc. Excludes non-profit institutions that are market producers of goods and services.

NOTE: This item is to be used for the reporting of revenues received from trusts or charities.

CODE 207 Corporations (other than health insurance)

This item is not currently required to be reported by state or territory health authorities.

Include revenues received from all corporations or quasi-corporations, whose principal activity is the production of market goods or services (other than health insurance). Included are all resident non-profit institutions that are market producers of goods or non-financial services. These include health or health-related organisations such as hospitals, pharmacies, medical and diagnostic laboratories, residential aged care facilities and providers of medical specialist services, and non-health organisations such as research organisations.

CODE 288 Other private sector revenue

Includes all private sector revenue other than those reported under codes 201 to 207.

CODE 301 Overseas

This item is not currently required to be reported by state or territory health authorities.

Includes funds provided from overseas countries for areas of health care such as research. Funds may be channelled through

government or non-government organisations or private institutions. Also includes overseas visitors receiving health care for whom travel insurance is the major funding source.

CODE 999 Not further defined

Includes all revenue that could be a combination of categories 101 to 108, 188, 201 to 207 and 288 but which could not be further disaggregated.

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Reference documents: Australian Institute of Health and Welfare 2007. Episode of care—principal source of funding, hospital code NN. Viewed 26 July 2007. <http://meteor.aihw.gov.au/content/index.phtml/itemId/339080>

Organisation for Economic Co-operation and Development A system of health accounts, Version 1. OECD 2000.

Australian Bureau of Statistics 2006, Australian and New Zealand Standard Industrial Classification (ANZSIC), 2006, cat. no. 1292.0, ABS, Canberra

Standard Economic Sector Classifications of Australia (SESCA), 2002, cat. no. 1218.0, ABS, Canberra

Private Health Insurance Act 2007 No. 31, 2007 Chapter 4, Part 4–3 at http://www.comlaw.gov.au/

Data element attributes

Collection and usage attributes

Guide for use: If there is an expected source of revenue followed by a finalised actual source of revenue (for example, in relation to compensation claims), then the actual revenue source known at the end of the reporting period should be recorded.

The expected revenue source should be reported if the fee has not been paid but is not to be waived.

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Relational attributes

Implementation in Data Set Specifications: Government health expenditure function revenue data cluster Health, Superseded 03/12/2008

Government health expenditure function revenue data element cluster Health, Standard 03/12/2008

Government health expenditure organisation revenue data element cluster Health, Superseded 03/12/2008

Government health expenditure organisation revenue data element cluster Health, Superseded 01/04/2009

Government health expenditure organisation revenue data element cluster Health, Standard 01/04/2009

Source of referral to alcohol and other drug treatment service

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—referral source, code NN
METeOR identifier:	269946
Registration status:	Health, Standard 01/03/2005
Definition:	The source from which the person was transferred or referred to the alcohol and other drug treatment service, as represented by a code.
Data Element Concept:	Episode of treatment for alcohol and other drugs—referral source

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Self
02	Family member/friend
03	Medical practitioner
04	Hospital
05	Mental health care service
06	Alcohol and other drug treatment service
07	Other community/health care service
08	Correctional service
09	Police diversion
10	Court diversion
98	Other

Supplementary values:

99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 03 Medical practitioner

Includes medical specialists, vocationally registered general practitioners, vocationally registered general practitioner trainees and other primary-care medical practitioners in private practice.

CODE 04 Hospital

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 psychiatric hospitals, psychiatric units and drug and alcohol units located within or operating from hospitals, and outpatient clinics (see codes 05-07).

CODE 05 Mental health care service

Includes both residential and non-residential services. Includes psychiatric hospitals and psychiatric units within and outside of hospitals.

CODE 06 Alcohol and other drug treatment service

Includes both residential and non-residential services. Includes drug and alcohol units within and outside of hospitals.

CODE 07 Other community/health care service

Includes outpatient clinics and aged care facilities.

CODE 09 Police diversion

This code should be used when a person detained for a minor drug offence is formally referred to treatment by the police in order to divert the offender from the criminal justice pathway.

CODE 10 Court diversion

This code refers to the diversion of an offender into drug education, assessment and treatment at the discretion of a magistrate. This may occur at the point of bail or prior to sentencing.

CODE 98 Other

Includes persons referred under a legislative act (other than Drug *Diversion Act*) e.g. *Mental Health Act*.

Data element attributes

Collection and usage attributes

Comments: Source of referral is important in assisting in the analyses of inter-sectoral patient/client flow and for health care planning.

Source and reference attributes

Submitting organisation: Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references: Supersedes Source of referral to alcohol and other drug treatment service, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.2 KB)

Implementation in Data Set Specifications: Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008
Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2010
Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Alcohol and other drug treatment services NMDS 2010-2011
Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Source of referral to public psychiatric hospital

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—referral source, public psychiatric hospital code NN
METeOR identifier:	269947
Registration status:	Health, Standard 01/03/2005
Definition:	Source from which the person was transferred/referred to the public psychiatric hospital, as represented by a code.
Context:	To assist in analyses of intersectoral patient flow and health care planning.
Data Element Concept:	Episode of admitted patient care—referral source

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
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

Supplementary values:

Value	Meaning
10	Unknown

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Source of referral to public psychiatric hospital, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)

Implementation in Data Set Specifications:

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised mental health service program type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—admitted patient care program type, code N
METeOR identifier:	288889
Registration status:	Health, Standard 08/12/2004
Definition:	Type of admitted patient care program provided by a specialised mental health service, as represented by a code.
Data Element Concept:	Specialised mental health service—admitted patient care program type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Acute care
2	Other

Collection and usage attributes

Guide for use:

The categorisation of the admitted patient program is based on the principal purpose(s) of the program rather than the classification of the individual patients.

CODE 1 Acute care

Programs primarily providing specialist psychiatric care for people with acute episodes of mental disorder. These episodes are characterised by recent onset of severe clinical symptoms of mental disorder that have potential for prolonged dysfunction or risk to self and/or others. The key characteristic of acute services is that this treatment effort is focused on short-term treatment. Acute services may be focused on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing mental disorder for whom there has been an acute exacerbation of symptoms. This category applies only to services with a mental health service setting of overnight admitted patient care or residential care.

CODE 2 Other

Refers to all other programs primarily providing admitted patient care.

Includes programs providing rehabilitation services that have a primary focus on intervention to reduce functional impairments

that limit the independence of patients. Rehabilitation services are focused on disability and the promotion of personal recovery.

They are characterised by an expectation of substantial improvement over the short to mid-term. Patients treated by rehabilitation services usually have a relatively stable pattern of clinical symptoms.

Also includes programs providing extended care services that primarily provide care over an indefinite period for patients who have a stable but severe level of functional impairment and an inability to function independently, thus requiring extensive care and support. Patients of extended care services present a stable pattern of clinical symptoms, which may include high levels of severe unremitting symptoms of mental disorder. Treatment is focused on preventing deterioration and reducing impairment; improvement is expected to occur slowly.

Data element attributes

Collection and usage attributes

Guide for use:

This data element is used to disaggregate data on beds, activity, expenditure and staffing for admitted patient settings in mental health service units (see Specialised mental health service—service setting, code N data element).

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Specialised mental health service setting

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—service setting, code N
METeOR identifier:	288899
Registration status:	Health, Standard 08/12/2004
Definition:	The setting for care provided by a specialised mental health service, as represented by a code.
Data Element Concept:	Specialised mental health service—service setting

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Admitted patient care setting
2	Residential care setting
3	Ambulatory care setting

Supplementary values:

9	Unknown/not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Admitted patient care setting

The component of specialised mental health services that provides admitted patient care. These are specialised psychiatric hospitals and specialist psychiatric units located within hospitals that are not specialised psychiatric hospitals. Excludes hospital outpatient clinics.

CODE 2 Residential care setting

The component of specialised mental health services that provides residential care within **residential mental health services**. Excludes components that provide ambulatory care to patients or clients who are not residents.

CODE 3 Ambulatory care setting

The component of specialised mental health services that provides ambulatory care (service contacts). They include hospital outpatient clinics and non-hospital community mental health services, such as crisis or mobile assessment and treatment services, day programs, outreach services and consultation/liaison services.

Data element attributes

Collection and usage attributes

Guide for use:

A single mental health service unit may provide care in more than one setting. This data element is intended to allow staffing, resource and expenditure data related to these settings to be identified and reported separately.

Relational attributes

Related metadata references:

Supersedes Specialised mental health service—service delivery setting, code N Health, Superseded 08/12/2004

Implementation in Data Set Specifications:

Community mental health establishments NMDS 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Specialised mental health service target population

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—target population group, code N
METeOR identifier:	288957
Registration status:	Health, Standard 08/12/2004
Definition:	The population group primarily targeted by a specialised mental health service, as represented by a code.
Data Element Concept:	Specialised mental health service—specialised mental health service target population group

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Child and adolescent
2	Older person
3	Forensic
4	General

Collection and usage attributes

Guide for use:

CODE 1 Child and adolescent

These services principally target children and young people under the age of 18 years. The classification of a service into this category requires recognition by the regional or central funding authority of the special focus of the service. These services may include a forensic component.

CODE 2 Older person

These services principally target people in the age group of 65 years and over. The classification of a service into this category requires recognition by the regional or central funding authority of the special focus of the service. These services may include a forensic component.

CODE 3 Forensic

Health services that provide services primarily for people whose health condition has led them to commit, or be suspected of, a criminal offence or make it likely that they will reoffend without adequate treatment or containment. This includes prison-based services, but excludes services that are primarily for children and

adolescents and for older people even where they include a forensic component.

CODE 4 General

These services principally target the general adult population (aged 18–64 years) but may also provide services to children, adolescents or older people. These services are those services that cannot be described as specialist child and adolescent services or services for older people. It excludes forensic services.

Data element attributes

Collection and usage attributes

Guide for use:

This data element is used to disaggregate data on beds, activity, expenditure and staffing for admitted patient settings in mental health service units (see service setting data element).

The order of priority for coding is:

- where the forensic services are for children/adolescents or older persons these services should be coded to the category for that age group; and
- where the forensic services are for adults these services should be coded to forensic.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health,

Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Specialised mental health service—hours staffed

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—number of hours staffed, average hours NN
METeOR identifier:	288877
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of hours per day during which a residential mental health service has appropriately trained staff employed on-site. Training may include formal qualifications and/or on the job training.
Data Element Concept:	Specialised mental health service—number of hours staffed

Value domain attributes

Representational attributes

Representation class:	Average	
Data type:	Number	
Format:	NN	
Maximum character length:	2	
Supplementary values:	Value	Meaning
	99	Unknown/not stated/inadequately described
Unit of measure:	Hour (h)	

Data element attributes

Collection and usage attributes

Guide for use:

Whole numbers of hours staffed (no decimals or fractions).

Valid numbers are 1 to 24.

The hours staffed provides a measure of service intensity for the reporting and analysis of staff, financial and activity data.

For residential mental health services, this refers to the number of hours per day during which appropriately trained staff (either with formal qualifications and/or on the job training) are employed on site, as their normal place of employment, within the service unit. It excludes periods where the service unit is only staffed by a resident sleepover staff member or any period where staff are present but not employed on site at the service unit.

Excludes ambulatory and admitted patient services.

Round to nearest whole hour.

Where the number of hours staffed varies by day, average the number of hours staffed over a week, including the weekend.

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Specialised mental health service—supported public housing places

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—number of supported public housing places, total N[N(5)]
METeOR identifier:	373054
Registration status:	Health, Standard 02/12/2009
Definition:	The total number of places in public housing supported by specialised mental health services available at 30 June, targeted to people affected by mental illness or psychiatric disability.
Data Element Concept:	Specialised mental health service—number of supported public housing places

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N(5)]
Maximum character length:	6

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	These are places provided by the public housing authority under a partnership agreement with the relevant State or Territory health and/or community service authority. Such agreements commit the State or Territory health and/or community service authority to assist people within their homes by providing ongoing clinical and disability support, including outreach services. 'Place' refers to capacity as at June 30, not throughput over the entire year.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Specialised mental health service—number of supported public housing places, total N[N(5)] Health, Superseded 02/12/2009

Implementation in Data Set Specifications:	Mental health establishments NMDS 2010-2011 Health, Standard 02/12/2009 *Implementation start date:* 01/07/2010

Specialised service indicators—acquired immune deficiency syndrome unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (acquired immune deficiency syndrome unit), yes/no code N
METeOR identifier:	270448
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the treatment of Acquired Immune Deficiency Syndrome (AIDS) patients is provided within an establishment as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—acute renal dialysis unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (acute renal dialysis unit), yes/no code N
METeOR identifier:	270435
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to dialysis of renal failure patients requiring acute care is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—acute spinal cord injury unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (acute spinal cord injury unit), yes/no code N
METeOR identifier:	270432
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not 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, is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—alcohol and drug unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (alcohol and drug unit), yes/no code N
METeOR identifier:	270431
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a facility/service dedicated to the treatment of alcohol and drug dependence is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—bone marrow transplantation unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (bone marrow transplantation unit), yes/no code N
METeOR identifier:	308862
Registration status:	Health, Standard 07/09/2005
Definition:	Whether or not a specialised facility for bone marrow transplantation is provided within the establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—burns unit (level III)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (burns unit (level III)), yes/no code N
METeOR identifier:	270438
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the initial treatment and subsequent rehabilitation of the severely injured burns patient (usually >10 per cent of the patient's body surface affected) is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—cardiac surgery unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (cardiac surgery unit), yes/no code N
METeOR identifier:	270434
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to operative and peri-operative care of patients with cardiac disease is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—clinical genetics unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (clinical genetics unit), yes/no code N
METeOR identifier:	270444
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to diagnostic and counselling services for clients who are affected by, at risk of, or anxious about genetic disorders, is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—comprehensive epilepsy centre

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (comprehensive epilepsy centre), yes/no code N
METeOR identifier:	270442
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to seizure characterisation, evaluation of therapeutic regimes, pre-surgical evaluation and epilepsy surgery for patients with refractory epilepsy, is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health,

Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—coronary care unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (coronary care unit), yes/no code N
METeOR identifier:	270433
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to acute care services for patients with cardiac diseases is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—diabetes unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (diabetes unit), yes/no code N
METeOR identifier:	270449
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the treatment of diabetics is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—domiciliary care service

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (domiciliary care service), yes/no code N
METeOR identifier:	270430
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not 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 is provided by the establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—geriatric assessment unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (geriatric assessment unit), yes/no code N
METeOR identifier:	270429
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not 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, is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health,

Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—heart, lung transplantation unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (heart, lung transplantation unit), yes/no code N
METeOR identifier:	308866
Registration status:	Health, Standard 07/09/2005
Definition:	Whether or not a specialised facility for heart including heart lung transplantation is provided within the establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—hospice care unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (hospice care unit), yes/no code N
METeOR identifier:	270427
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a facility dedicated to the provision of palliative care to terminally ill patients is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—in-vitro fertilisation unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (in-vitro fertilisation unit), yes/no code N
METeOR identifier:	270441
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the investigation of infertility provision of in-vitro fertilisation services is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—infectious diseases unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (infectious diseases unit), yes/no code N
METeOR identifier:	270447
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the treatment of infectious diseases is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—intensive care unit (level III)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (intensive care unit (level III)), yes/no code N
METeOR identifier:	270426
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the care of paediatric and adult patients requiring intensive care and sophisticated technological support services is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—liver transplantation unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (liver transplantation unit), yes/no code N
METeOR identifier:	308868
Registration status:	Health, Standard 07/09/2005
Definition:	Whether or not a specialised facility for liver transplantation is provided within the establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—maintenance renal dialysis centre

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (maintenance renal dialysis centre), yes/no code N
METeOR identifier:	270437
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a specialised facility dedicated to maintenance dialysis of renal failure patients, as represented by a code. 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.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health,

Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—major plastic/reconstructive surgery unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (major plastic/reconstructive surgery unit), yes/no code N
METeOR identifier:	270439
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to general purpose plastic and specialised reconstructive surgery, including maxillofacial, microsurgery and hand surgery, is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—neonatal intensive care unit (level III)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (neonatal intensive care unit (level III)), yes/no code N
METeOR identifier:	270436
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the care of neonates requiring care and sophisticated technological support, is provided within an establishment, as represented by a code. Patients usually require intensive cardiorespiratory monitoring, sustained assistance ventilation, long-term oxygen administration and parenteral nutrition.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—neurosurgical unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (neurosurgical unit), yes/no code N
METeOR identifier:	270446
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the surgical treatment of neurological conditions is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—nursing home care unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (nursing home care unit), yes/no code N
METeOR identifier:	270428
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a facility dedicated to the provision of nursing home care is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—obstetric/maternity

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (obstetric/maternity), yes/no code N
METeOR identifier:	270150
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the care of obstetric/maternity patients is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—oncology unit, cancer treatment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (oncology unit) (cancer treatment), yes/no code N
METeOR identifier:	270440
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to multidisciplinary investigation, management, rehabilitation and support services for cancer patients, is provided within an establishment, as represented by a code. Treatment services include surgery, chemotherapy and radiation.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health,

Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—pancreas transplantation unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (pancreas transplantation unit), yes/no code N
METeOR identifier:	308870
Registration status:	Health, Standard 07/09/2005
Definition:	Whether or not a specialised facility for pancreas transplantation is provided within the establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—psychiatric unit/ward

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (psychiatric unit/ward), yes/no code N
METeOR identifier:	270425
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised unit/ward dedicated to the treatment and care of admitted patients with psychiatric, mental, or behavioural disorders, is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—rehabilitation unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (rehabilitation unit), yes/no code N
METeOR identifier:	270450
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not dedicated units within recognised hospitals which provide post-acute rehabilitation and are designed as such by the State health authorities (see metadata item Type of episode of care) are provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—renal transplantation unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (renal transplantation unit), yes/no code N
METeOR identifier:	308864
Registration status:	Health, Standard 07/09/2005
Definition:	Whether or not a specialised facility for renal transplantation is provided within the establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—sleep centre

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (sleep centre), yes/no code N
METeOR identifier:	270445
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility linked to a sleep laboratory dedicated to the investigation and management of sleep disorders is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references: Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—specialist paediatric

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (specialist paediatric), yes/no code N
METeOR identifier:	270424
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to the care of children aged 14 or less is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)
Implementation in Data Set Specifications:	Public hospital establishments NMDS Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—transplantation unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—specialised service indicator (transplantation unit), yes/no code N
METeOR identifier:	270443
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a specialised facility dedicated to organ retrieval, transplantation and ongoing care of the transplant recipient, is provided within an establishment. • bone marrow • renal • heart, including heart-lung • liver • pancreas.
Data Element Concept:	Establishment—specialised service indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)

Specialist private sector rehabilitation care indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—specialist private sector rehabilitation care indicator, code N
METeOR identifier:	270397
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the rehabilitation care that a patient receives from a private hospital meets the criteria for 'Specialist private sector rehabilitation care', as represented by a code.
Data Element Concept:	Episode of care—specialist private sector rehabilitation care indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

This metadata item is a qualifier of the three 'Rehabilitation' care types for admitted patients in private hospitals. When an admitted patient in a private hospital is receiving rehabilitation care (as defined in Hospital service—care type, code N[N].N), this metadata item should be recorded to denote whether or not that care meets the criteria for 'specialist rehabilitation'.

These are the criteria determined by The Commonwealth Department of Health and Ageing in respect of patients treated in the private sector, specialist rehabilitation is:

- Provided by a specialist rehabilitation unit (a separate physical space and a specialist rehabilitation team providing admitted patient and/or ambulatory care) meeting guidelines issued by the Commonwealth Department of Health and Ageing, and
- provided by a multi-disciplinary team which is under the clinical management of a consultant in rehabilitation medicine or equivalent, and
- provided for a person with limited functioning (impairments, activity limitations and participation restrictions) and for whom there is a reasonable expectation of functional gain, and

- for whom the primary treatment goal is improvement in functioning status which is evidenced in the medical record by:

  an individualised and documented initial and periodic assessment of functional ability, or

  an individualised multi-disciplinary rehabilitation plan which includes agreed rehabilitation goals and indicative timeframes.

Comments: This metadata item has been developed by the Private Rehabilitation Working Group, and agreed by the private rehabilitation hospital sector, the private health insurance sector and the Commonwealth Department of Health and Ageing. Whilst most patients will be treated by a consultant in rehabilitation medicine (a Fellow of the Australasian Faculty of Rehabilitation Medicine) there are circumstances in which the treating doctor will not be a Fellow of the Faculty. These include, but are not limited to, care provided in geographic areas where there is a shortage of Fellows of the Australasian Faculty of Rehabilitation Medicine.

Source and reference attributes

Submitting organisation: Private Rehabilitation Working Group

Commonwealth Department of Health and Ageing

Staging basis of cancer

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer staging—staging basis of cancer, code A
METeOR identifier:	296981
Registration status:	Health, Standard 04/06/2004
Definition:	The timing and evidence for T, N and M cancer stage values, as represented by a code.
Data Element Concept:	Cancer staging—staging basis of cancer

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A
Maximum character length:	1

Permissible values:

Value	Meaning
P	Pathological
C	Clinical

Collection and usage attributes

Guide for use:

CODE P Pathological

Pathological stage is based on histological evidence acquired before treatment, supplemented or modified by additional evidence acquired from surgery and from pathological examination.

CODE C Clinical

Clinical stage is based on evidence obtained prior to treatment from physical examination, imaging, endoscopy, biopsy, surgical exploration or other relevant examinations.

Refer to the latest edition of the UICC reference manual TNM Classification of Malignant Tumours for coding rules.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Collection methods:	From information provided by the treating doctor and recorded on the patient's medical record.

Relational attributes

Implementation in Data Set Specifications:

Cancer (clinical) DSS Health, Superseded 07/12/2005
Cancer (clinical) DSS Health, Superseded 06/03/2009
Cancer (clinical) DSS Health, Superseded 22/12/2009
Cancer (clinical) DSS Health, Standard 22/12/2009

Staging scheme source

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer staging—cancer staging scheme source, code N
METeOR identifier:	296988
Registration status:	Health, Standard 04/06/2004
Definition:	The reference which describes in detail the methods of staging and the definitions for the classification system used in determining the extent of cancer at the time of diagnosis, as represented by a code.
Data Element Concept:	Cancer staging—cancer staging scheme source

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	TNM Classification of Malignant Tumours (UICC)
2	Durie & Salmon for multiple myeloma staging
3	FAB for leukaemia classification
4	Australian Clinico-Pathological Staging (ACPS) System
8	Other

Supplementary values:

Value	Meaning
9	Unknown

Source and reference attributes

Reference documents:

Durie BGM, Salmon SE. *A clinical staging system for multiple myeloma correlation of measured myeloma cell mass with presenting clinical features, response to treatment and survival.* Cancer 36:842-54 (1975).

Bennett JM, Catovsky D, Daniel MT, Flandrin G, Galton DA, Gralnick HR, Sultan C. *Proposed revised criteria for the classification of acute myeloid leukemia: a report of the French-American-British Cooperative Group.* Ann Intern Med 103(4): 620-625 (1985).

Cheson BD, Cassileth PA, Head DR, Schiffer CA, Bennett JM, Bloomfield CD, Brunning R, gale RP, Grever MR, Keating MJ, et al. *Report of the National Cancer Institute-sponsored workshop on definitions of diagnosis and response in acute myeloid leukemia.* J Clin Oncol 8(5): 813-819 (1990).

Davis NC, Newland RC. *The reporting of colorectal cancer: the Australian Clinicopathological Staging system.* Aust NZ J Surg

52:395-397 (1982).

Public Health Division *NSW Clinical Cancer Data Collection for Outcomes and Quality. Data Dictionary Version 1* Sydney NSW Health Dept (2001).

NHMRC *Guidelines for the prevention, early detection and management of colorectal cancer (CRC)* (1999)).

Data element attributes

Collection and usage attributes

Guide for use:

It is recommended that the TNM Manual of the UICC be used whenever it is applicable. The classifications published in the American Joint Committee on Cancer (AJCC) Cancer Staging Manual are identical to the TNM classifications of the UICC.

TNM is not applicable to all tumour sites. Staging is of limited use in acute leukaemias, although a staging system is used for chronic lymphocytic leukaemia. Separate staging systems exist for lymphomas and myeloma. The *NHMRC Guidelines for the prevention, early detection and management of colorectal cancer (CRC)* support the use of the Australian Clinico-Pathological Staging (ACPS) System. A table of correspondences between ACPS and TNM classifications is available.

The current edition of each staging scheme should be used.

Source and reference attributes

Origin:

International Union Against Cancer (UICC).

FAB (French-American-British) Group.

NSW Health Department.

National Health & Medical Research Council.

Clinical Oncological Society of Australia.

Australian Cancer Network.

Relational attributes

Related metadata references:

Supersedes Staging scheme source, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.8 KB)

See also Cancer staging—cancer staging scheme source edition number, code N[N] Health, Standard 04/06/2004

Implementation in Data Set Specifications:

Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Superseded 06/03/2009

Conditional obligation:
Recorded if the recommended data standard is not used, e.g. the recommended standard specifies the 6th edition, but the 5th edition is used; or if another classification (not the TNM) is used to stage the cancer, e.g. FAB for leukaemia classification is used.

Cancer (clinical) DSS Health, Superseded 22/12/2009

Cancer (clinical) DSS Health, Standard 22/12/2009

Staging scheme source edition number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer staging—cancer staging scheme source edition number, code N[N]
METeOR identifier:	297011
Registration status:	Health, Standard 04/06/2004
Definition:	The edition of the reference used for the purposes of staging the cancer, as represented by a code.
Data Element Concept:	Cancer staging—cancer staging scheme source edition number

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]

Supplementary values:

Value	Meaning
88	Not applicable (Cases that do not have a recommended staging scheme)
99	Unknown edition

Collection and usage attributes

Guide for use: Record the edition number (i.e. 1 - 87).

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Origin: Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998).

Relational attributes

Related metadata references: Supersedes Staging scheme source edition number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.7 KB)

Implementation in Data Set Specifications:

Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Superseded 06/03/2009

Conditional obligation:
Recorded if the recommended data standard is not used, e.g. the recommended standard specifies the 6th edition, but the 5th edition is used; or if another classification (not the TNM)

is used to stage the cancer, e.g. FAB for leukaemia classification is used.

Cancer (clinical) DSS Health, Superseded 22/12/2009

Cancer (clinical) DSS Health, Standard 22/12/2009

Standards assessment indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—standards assessment indicator, yes/no code N
METeOR identifier:	356457
Registration status:	Health, Standard 05/12/2007
Definition:	Whether a service provider organisation routinely undertakes or undergoes formal assessment against defined industry standards, as represented by a code.
Data Element Concept:	Service provider organisation—standards assessment indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

Formal assessment against the relevant standards may occur via self-assessment or external assessment methods. A 'formal' self-assessment should involve a number of aspects, including the planning and development of a clear structure for the assessment process; the use of an accepted evaluation method such as a peer review; and the use of validated tools where these are available. A 'formal' assessment also includes a formal in-depth review against the relevant standards by an independent external reviewer. This may take place in the context of an accreditation process for the service provider organisation or the organisation of which the service provider organisation is a sub-unit.

CODE 1 Yes
The service provider organisation routinely undertakes or undergoes formal assessment against the specified healthcare standards.

CODE 2 No
The service provider organisation does not routinely undertake or undergo formal assessment against the specified healthcare standards.

Collection methods:

Record only one code.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications: Palliative care performance indicators DSS Health, Standard 05/12/2007

Standards assessment level

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—standards assessment level, code N
METeOR identifier:	359019
Registration status:	Health, Standard 05/12/2007
Definition:	The level of assessment undertaken or undergone by a service provider organisation against relevant industry standards as represented by a code.
Data Element Concept:	Service provider organisation—standards assessment level

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Formally assessed
2	Accredited

Collection and usage attributes

Guide for use:

CODE 1 Formally assessed

Formal assessment may entail self-assessment and/or assessment by an independent external reviewer. This assessment may take place in the context of an accreditation process for the organisation.

A formal assessment, whether self-assessed or externally reviewed, should involve a number of aspects, including the planning and development of a clear structure for the assessment process, the use of an accepted evaluation method such as a peer review, and the use of validated tools where these are available.

CODE 2 Accredited

This code should only be recorded where accreditation has been granted to the organisation and is current.

Data element attributes

Source and reference attributes

Submitting organisation:	Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications:

Palliative care performance indicators DSS Health, Standard 05/12/2007

Conditional obligation:
Recorded when the data element Service provider organisation—standards assessment indicator, yes/no code N value is 'yes' (code 1).

Standards assessment method

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—standards assessment method, code N
METeOR identifier:	287762
Registration status:	Health, Standard 05/12/2007
Definition:	The method used by a service provider organisation to undertake or undergo formal assessment against defined industry standards, as represented by a code.
Data Element Concept:	Service provider organisation—standards assessment method

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Formal self-assessment
2	In-depth external review

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Formal self-assessment

The service provider organisation undertakes formal self-assessment, on a routine basis, against the agreed criteria outlined in the defined industry standards.

A formal self-assessment should involve a number of aspects, including the planning and development of a clear structure for the assessment process; the use of an accepted evaluation method such as a peer review; and the use of validated tools where these are available.

CODE 2 In-depth external review

The service provider organisation routinely undergoes an in-depth review against the defined industry standards by an independent external reviewer. This may take place in the context of an accreditation process for the service provider organisation.

Collection methods: More than one code can be recorded.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications: Palliative care performance indicators DSS Health, Standard 05/12/2007

Conditional obligation:
Recorded when the data element *Service provider organisation – standards assessment indicator, yes/no code N* value is 'yes' (code 1).

State/Territory of birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—state/territory of birth, code N
METeOR identifier:	270151
Registration status:	Health, Standard 01/03/2005
Definition:	The state/territory in which the baby was delivered, as represented by a code.
Data Element Concept:	Birth event—state/territory of birth

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
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)

Collection and usage attributes

Guide for use:	The order presented here is the standard for the Australian Bureau of Statistics (ABS). Other organisations (including the Australian Institute of Health and Welfare) publish data in state order based on population (that is, Western Australia before South Australia and Australian Capital Territory before Northern Territory).

Source and reference attributes

Reference documents:	Australian Bureau of Statistics. Australian Standard Geographical Classification (ASGC). Cat No. 1216.0. Canberra: ABS.

Data element attributes

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes State/Territory of birth, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.2 KB)

Implementation in Data Set Specifications:

Health care client identification Health, Superseded 04/05/2005

Health care client identification DSS Health, Superseded 03/12/2008

Health care client identification DSS Health, Standard 03/12/2008

Perinatal NMDS Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Perinatal NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Perinatal NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Status of the baby

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth—birth status, code N
METeOR identifier:	269949
Registration status:	Health, Standard 01/03/2005
Definition:	The status of the baby at birth as represented by a code.
Data Element Concept:	Birth—birth status

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Live birth
	2	Stillbirth (fetal death)
Supplementary values:	9	Not stated

Collection and usage attributes

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 fetal 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 fetus 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 fetal death, except that there are no limits of gestational age or birthweight for the WHO definition.)

Source and reference attributes

Reference documents:

International Classification of Diseases and Related Health Problems, 10th Revision, Vol 1, WHO 1992.

Data element attributes

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Status of the baby, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.9 KB)

Implementation in Data Set Specifications:

Perinatal NMDS Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Perinatal NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2010 Health, Superseded 02/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Perinatal NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Street name (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—street name, text [A(30)]
Synonymous names:	Australian street name
METeOR identifier:	270019
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	The concatenation of a person's street type and street suffix resulting in a name that identifies a public thoroughfare and differentiates it from others in the same suburb/town/locality, as represented by text.
Data Element Concept:	Person (address)—street name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[A(30)]
Maximum character length:	30

Data element attributes

Collection and usage attributes

Guide for use:	To be used in conjunction with street type. To be used in conjunction with street suffix.
Comments:	Where suburb/town/locality, state/territory and Postcode - Australian are insufficient to assign a Statistical Local Area (SLA) code from the Australian Standard Geographical Classification (Australian Bureau of Statistics, Cat. No. 1216.0), the Street name metadata item in conjunction with street type, house/property identifier and street suffix should also be used.

Source and reference attributes

Origin:	Health Data Standards Committee Australia Post Address Presentation Standard
Reference documents:	AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

Related metadata references:	Supersedes Street name, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB) Is used in the formation of Person (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

	Is used in the formation of Person (address) — health address line, text [X(180)] Health, Superseded 04/05/2005
Implementation in Data Set Specifications:	Health care client identification DSS Health, Superseded 03/12/2008
	Health care client identification DSS Health, Standard 03/12/2008
	Health care provider identification DSS Health, Superseded 04/07/2007
	Health care provider identification DSS Health, Superseded 03/12/2008
	Health care provider identification DSS Health, Standard 03/12/2008

Street name (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—street name, text [A(30)]
METeOR identifier:	290218
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The concatenation of an organisation's street type and street suffix resulting in a name that identifies a public thoroughfare and differentiates it from others in the same suburb/town/locality, as represented by text.
Data Element Concept:	Service provider organisation (address)—street name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[A(30)]
Maximum character length:	30

Data element attributes

Collection and usage attributes

Guide for use:	To be used in conjunction with street type. To be used in conjunction with street suffix.
Comments:	Where suburb/town/locality, state/territory and Postcode - Australian are insufficient to assign a Statistical Local Area (SLA) code from the Australian Standard Geographical Classification (Australian Bureau of Statistics, Cat. No. 1216.0), the Street name metadata item in conjunction with Street type, House/property identifier and Street suffix should also be used.

Source and reference attributes

Origin:	Health Data Standards Committee Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Is used in the formation of Service provider organisation (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005
Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Superseded 03/12/2008

Health care provider identification DSS Health, Standard
03/12/2008

Street suffix code (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—street suffix, code A[A]
METeOR identifier:	270022
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	The abbreviated suffix that identifies the type of street where a person resides, as represented by a code.
Data Element Concept:	Person (address)—street suffix

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A[A]
Maximum character length:	2

Permissible values:

Value	Meaning
CN	Central
E	East
EX	Extension
LR	Lower
N	North
NE	North East
NW	North West
S	South
SE	South East
SW	South West
UP	Upper
W	West

Data element attributes

Collection and usage attributes

Collection methods:	To be used in conjunction with street name. To be used in conjunction with street type. For example: Browns Rd W

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Origin: AS4590 Interchange of client information, Australia Post Address Presentation Standard

Relational attributes

Related metadata references:

Supersedes Street suffix code, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.9 KB)

Is used in the formation of Person (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is used in the formation of Person (address)—health address line, text [X(180)] Health, Superseded 04/05/2005

Implementation in Data Set Specifications:

Health care client identification DSS Health, Superseded 03/12/2008

Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Superseded 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Street suffix code (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—street suffix, code A[A]
METeOR identifier:	290170
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The abbreviated suffix that identifies the type of street where an organisation is located, as represented by a code.
Data Element Concept:	Service provider organisation (address)—street suffix

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A[A]
Maximum character length:	2

Permissible values:

Value	Meaning
CN	Central
E	East
EX	Extension
LR	Lower
N	North
NE	North East
NW	North West
S	South
SE	South East
SW	South West
UP	Upper
W	West

Data element attributes

Collection and usage attributes

Collection methods:	To be used in conjunction with street name. To be used in conjunction with street type. For example: Browns Rd W

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Origin: AS4590 Interchange of client information, Australia Post Address Presentation Standard

Relational attributes

Related metadata references: Is used in the formation of Service provider organisation (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Implementation in Data Set Specifications: Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Superseded 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Street type code (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—street type, code A[AAA]
METeOR identifier:	270020
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	The type of public thoroughfare where a person resides, as represented by a code.
Data Element Concept:	Person (address)—street type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A[AAA]
Maximum character length:	4

Collection and usage attributes

Guide for use: The following is a list of commonly used abbreviations from AS 4590:

Street Type	Abbreviation
Alley	Ally
Arcade	Arc
Avenue	Ave
Boulevard	Bvd
Bypass	Bypa
Circuit	Cct
Close	Cl
Corner	Crn
Court	Ct
Crescent	Cres
Cul-de-sac	Cds
Drive	Dr
Esplanade	Esp
Green	Grn
Grove	Gr
Highway	Hwy

Junction	Jnc
Lane	Lane
Link	Link
Mews	Mews
Parade	Pde
Place	Pl
Ridge	Rdge
Road	Rd
Square	Sq
Street	St
Terrace	Tce

Data element attributes

Source and reference attributes

Submitting organisation: Standards Australia

Origin: Health Data Standards Committee

AS4590 Interchange of client information, Australia Post Address Presentation Standard

Relational attributes

Related metadata references: Supersedes Street type code, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.8 KB)

Is used in the formation of Person (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is used in the formation of Person (address)—health address line, text [X(180)] Health, Superseded 04/05/2005

Implementation in Data Set Specifications: Health care client identification DSS Health, Superseded 03/12/2008

Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Superseded 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Street type code (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—street type, code A[AAA]
METeOR identifier:	290193
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The type of public thoroughfare where an organisation is located, as represented by a code.
Data Element Concept:	Service provider organisation (address)—street type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A[AAA]
Maximum character length:	4

Collection and usage attributes

Guide for use: The following is a list of commonly used abbreviations from AS 4590:

Street Type	Abbreviation
Alley	Ally
Arcade	Arc
Avenue	Ave
Boulevard	Bvd
Bypass	Bypa
Circuit	Cct
Close	Cl
Corner	Crn
Court	Ct
Crescent	Cres
Cul-de-sac	Cds
Drive	Dr
Esplanade	Esp
Green	Grn
Grove	Gr

Highway	Hwy
Junction	Jnc
Lane	Lane
Link	Link
Mews	Mews
Parade	Pde
Place	Pl
Ridge	Rdge
Road	Rd
Square	Sq
Street	St
Terrace	Tce

Data element attributes

Collection and usage attributes

Collection methods: To be collected in conjunction with street name. To be collected in conjunction with street suffix.

Source and reference attributes

Origin: AS4590 Interchange of client information, Australia Post Address Presentation Standard

Relational attributes

Related metadata references: Is used in the formation of Service provider organisation (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Implementation in Data Set Specifications: Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Superseded 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Suburb/town/locality name (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—suburb/town/locality name, text [A(50)]
METeOR identifier:	287326
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005
Definition:	The full name of the locality contained within the specific address of a person, as represented by text.
Data Element Concept:	Person (address)—suburb/town/locality name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[A(50)]
Maximum character length:	50

Data element attributes

Collection and usage attributes

Guide for use:	The suburb/town/locality name may be a town, city, suburb or commonly used location name such as a large agricultural property or Aboriginal community. This metadata item may be used to describe the location of person. It can be a component of a street or postal address. The Australian Bureau of Statistics has suggested that a maximum field length of 50 characters should be sufficient to record the vast majority of locality names.
Collection methods:	Enter 'Unknown' when the locality name or geographic area for a person or event is not known. Enter 'No fixed address' when a person has no fixed address or is **homeless**.

Source and reference attributes

Origin:	National Health Data Committee National Community Services Data Committee
Reference documents:	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia Australia Post 2005. Australia Postcode File. Viewed 12 April, www.auspost.com.au/postcodes

Relational attributes

Related metadata references:

Supersedes Person (address)—suburb/town/locality name, text [A(50)] Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005

Is used in the formation of Person (address)—postal delivery point identifier, {N(8)} Health, Standard 04/05/2005, Community services, Standard 25/08/2005

Is used in the formation of Dwelling—geographic location, remoteness structure code (ASGC 2004) N[N] Housing assistance, Retired 10/02/2006

Implementation in Data Set Specifications:

Computer Assisted Telephone Interview demographic module DSS Health, Superseded 03/12/2008

Computer Assisted Telephone Interview demographic module DSS Health, Standard 03/12/2008

Health care client identification DSS Health, Superseded 03/12/2008

Health care client identification DSS Health, Standard 03/12/2008

Health care provider identification DSS Health, Superseded 04/07/2007

Health care provider identification DSS Health, Superseded 03/12/2008

Health care provider identification DSS Health, Standard 03/12/2008

Registered chiropractic labour force DSS Health, Standard 10/12/2009

Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009

Registered medical professional labour force DSS Health, Standard 10/12/2009

Registered midwifery labour force DSS Health, Standard 10/12/2009

Registered nursing professional labour force DSS Health, Standard 10/12/2009

Registered optometry labour force DSS Health, Standard 10/12/2009

Registered osteopathy labour force DSS Health, Standard 10/12/2009

Registered pharmacy labour force DSS Health, Standard 10/12/2009

Registered physiotherapy labour force DSS Health, Standard 10/12/2009

Registered podiatry labour force DSS Health, Standard 10/12/2009

Registered psychology labour force DSS Health, Standard 10/12/2009

Suburb/town/locality name (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—suburb/town/locality name, text [A(50)]
METeOR identifier:	290059
Registration status:	Health, Standard 04/05/2005 Community services, Standard 31/08/2005
Definition:	The full name of the general locality containing the specific address of an organisation, as represented by text.
Data Element Concept:	Service provider organisation (address)—suburb/town/locality name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[A(50)]
Maximum character length:	50

Data element attributes

Collection and usage attributes

Guide for use:	The suburb/town/locality name may be a town, city, suburb or commonly used location name such as a large agricultural property or Aboriginal community. The Australian Bureau of Statistics has suggested that a maximum field length of 50 characters should be sufficient to record the vast majority of locality names. This metadata item may be used to describe the location of an organisation. It can be a component of a street or postal address.
Collection methods:	Enter 'Unknown' when the locality name or geographic area for an organisation is not known.

Source and reference attributes

Origin:	National Health Data Committee National Community Services Data Committee Australia Post 2005. Australia Postcode File. Viewed 12 April www.auspost.com.au/postcodes
Reference documents:	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references:	Is used in the formation of Service provider organisation (address) — postal delivery point identifier, {N(8)} Health, Standard 04/05/2005, Community services, Standard 31/08/2005
Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007
	Health care provider identification DSS Health, Superseded 03/12/2008
	Health care provider identification DSS Health, Standard 03/12/2008

Suburb/town/locality name (workplace)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Workplace (address)—suburb/town/locality name, text [A(50)]
METeOR identifier:	386195
Registration status:	Health, Standard 10/12/2009
Definition:	The full name of the general locality containing the specific address of a workplace, as represented by text.
Data Element Concept:	Workplace (address)—suburb/town/locality name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[A(50)]
Maximum character length:	50

Data element attributes

Collection and usage attributes

Guide for use:	The suburb/town/locality name may be a town, city, suburb or commonly used location name such as a large agricultural property or Aboriginal community. The Australian Bureau of Statistics has suggested that a maximum field length of 50 characters should be sufficient to record the vast majority of locality names. This metadata item may be used to describe the location of a workplace. It can be a component of a street or postal address.
Collection methods:	Enter 'Unknown' when the locality name or geographic area for an organisation is not known.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:	Main job of registered chiropractor cluster Health, Standard 10/12/2009 Main job of registered dental and allied dental health professional cluster Health, Standard 10/12/2009 Main job of registered medical professional cluster Health, Standard 10/12/2009 Main job of registered midwife cluster Health, Standard 10/12/2009

Main job of registered nursing professional cluster Health, Standard 10/12/2009

Main job of registered optometrist cluster Health, Standard 10/12/2009

Main job of registered osteopath cluster Health, Standard 10/12/2009

Main job of registered pharmacist cluster Health, Standard 10/12/2009

Main job of registered physiotherapist cluster Health, Standard 10/12/2009

Main job of registered podiatrist cluster Health, Standard 10/12/2009

Main job of registered psychologist cluster Health, Standard 10/12/2009

Second job of registered chiropractor cluster Health, Standard 10/12/2009

Second job of registered dental and allied dental health professional cluster Health, Standard 10/12/2009

Second job of registered medical professional cluster Health, Standard 10/12/2009

Second job of registered midwife cluster Health, Standard 10/12/2009

Second job of registered nursing professional cluster Health, Standard 10/12/2009

Second job of registered optometrist cluster Health, Standard 10/12/2009

Second job of registered osteopath cluster Health, Standard 10/12/2009

Second job of registered pharmacist cluster Health, Standard 10/12/2009

Second job of registered physiotherapist cluster Health, Standard 10/12/2009

Second job of registered podiatrist cluster Health, Standard 10/12/2009

Second job of registered psychologist cluster Health, Standard 10/12/2009

Surgical specialty

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—surgical specialty (of scheduled doctor), code NN
METeOR identifier:	270146
Registration status:	Health, Standard 01/03/2005
Definition:	The area of clinical expertise held by the doctor who will perform the elective surgery, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode—surgical specialty (of scheduled doctor)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
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

Collection and usage attributes

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).

Data element attributes

Source and reference attributes

Submitting organisation: Hospital Access Program Waiting Lists Working Group

Waiting Times Working Group

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Surgical specialty, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (15.7 KB)

Implementation in Data Set Specifications: Elective surgery waiting times (census data) NMDS Health, Superseded 07/12/2005

Implementation start date: 30/09/2002

Implementation end date: 30/06/2006

Elective surgery waiting times (census data) NMDS 2006-2009 Health, Superseded 03/12/2008

Implementation start date: 30/09/2006

Implementation end date: 31/03/2009

Elective surgery waiting times (census data) NMDS 2009- Health, Standard 03/12/2008

Implementation start date: 30/06/2009

Elective surgery waiting times (removals data) NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2002

Implementation end date: 30/06/2006

Elective surgery waiting times (removals data) NMDS 2006-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2006

Implementation end date: 30/06/2009

Elective surgery waiting times (removals data) NMDS 2009- Health, Standard 03/12/2008

Implementation start date: 01/07/2009

Surgical treatment procedure for cancer

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—surgical procedure for cancer, procedure code (ACHI 7th edn) NNNNN-NN
METeOR identifier:	391347
Registration status:	Health, Standard 22/12/2009
Definition:	The surgical procedure used in the primary treatment of the cancer, as represented by a code.
Data Element Concept:	Cancer treatment—surgical procedure for cancer

Value domain attributes

Representational attributes

Classification scheme:	Australian Classification of Health Interventions (ACHI) 7th edition
Representation class:	Code
Data type:	Number
Format:	NNNNN-NN
Maximum character length:	7

Data element attributes

Collection and usage attributes

Guide for use:	Each surgical treatment procedure used in the initial treatment of the cancer should be recorded. Surgical procedures performed for palliative purposes only should not be included. For surgical procedures involved in the administration of another modality (e.g. implantation of infusion pump, isolated limb perfusion/infusion, intra-operative radiotherapy) record both the surgery and the other modality. Any systemic treatment which can be coded as a procedure through ACHI should be so coded (e.g. stem cell or bone marrow infusion).

Source and reference attributes

Submitting organisation:	National Cancer Control Initiative
Origin:	National Centre for Classification in Health New South Wales Department of Health, Public Health Division
Reference documents:	NSW Department of Health NSW Clinical Cancer Data Collection for Outcomes and Quality. Data Dictionary Version 1 (2001).

Relational attributes

Related metadata references:	Supersedes Cancer treatment—surgical procedure for cancer,

	procedure code (ACHI 6th edn) NNNNN-NN Health, Superseded 22/12/2009
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Standard 22/12/2009

Systemic therapy agent name

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—systemic therapy agent name (primary cancer), antineoplastic drug code (Self-Instructional Manual for Tumour Registrars Book 8 3rd edn) X[X(39)]
METeOR identifier:	288446
Registration status:	Health, Standard 04/06/2004
Definition:	The chemotherapeutic agent or anti-cancer drug used for treatment of the primary cancer, as represented by a code.
Data Element Concept:	Cancer treatment—systemic therapy agent name (primary cancer)

Value domain attributes

Representational attributes

Classification scheme:	Self-Instructional Manual for Tumour Registrars Book 8 Antineoplastic Drugs, 3rd edition
Representation class:	Code
Data type:	String
Format:	X[X(39)]
Maximum character length:	40

Data element attributes

Collection and usage attributes

Guide for use:	The purpose of collecting specific treatment information is to account for all treatment types, which may assist in evaluation of effectiveness of different treatment patterns. The actual agents used will sometimes be of interest. Systemic therapy often involves treatment with a combination of agents. These may be known by acronyms but since details of drugs and acronyms may vary it is recommended that each agent be recorded separately. Oral chemotherapy normally given on an outpatient basis should also be included. New codes and names will need to be added as new agents become available for clinical use. Hormone therapy agents and immunotherapy agents should be recorded under this data element.
Collection methods:	The full name of the agent(s) should be recorded if the coding manual is not available.
Comments:	Collecting dates for systemic therapy will allow evaluation of treatments delivered and of time intervals from diagnosis to treatment, from treatment to recurrence and from treatment to death.

Source and reference attributes

Origin:	National Cancer Institute Surveillance, Epidemiology and End Results (SEER) Program
Reference documents:	Surveillance, Epidemiology and End Results (SEER) Program Self-instructional manual for tumour registrars: Book 8 - Antineoplastic drugs 3rd Edition National Cancer Institute.

Relational attributes

Related metadata references:	Supersedes Systemic therapy agent name, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.5 KB)
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005
	Cancer (clinical) DSS Health, Superseded 06/03/2009
	Cancer (clinical) DSS Health, Superseded 22/12/2009
	Cancer (clinical) DSS Health, Standard 22/12/2009

Teaching status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—teaching status (university affiliation), code N
METeOR identifier:	270148
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator to identify the non-direct patient care activity of teaching for a particular establishment, as represented by a code.
Data Element Concept:	Establishment—teaching status (university affiliation)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Unknown

Data element attributes

Collection and usage attributes

Guide for use:

In this context, teaching relates to teaching hospitals affiliated with universities providing undergraduate medical education as advised by the relevant state health authority.

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).

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Teaching status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.1 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Telephone number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—telephone number, text [X(40)]
METeOR identifier:	270266
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005
Definition:	The person's contact telephone number, as represented by text.
Data Element Concept:	Person—telephone number

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(40)]
Maximum character length:	40

Data element attributes

Collection and usage attributes

Guide for use:	More than one phone number may be recorded as required. Each phone number should have an appropriate telephone number type code assigned. Record the full phone number (including any prefixes) with no punctuation (hyphens or brackets).
Collection methods:	Prefix plus telephone number: Record the prefix plus telephone number. The default should be the local prefix with an ability to overtype with a different prefix. For example, 08 8226 6000 or 0417 123456. Punctuation: Do not record punctuation. For example, (08) 8226 6000 or 08-8226 6000 would not be correct. Unknown: Leave the field blank.
Comments:	Concerned with the use of person identification data. For organisations that create, use or maintain records on people. Organisations should use this standard, where appropriate, for collecting data when registering people. The positive and unique identification of people is a critical event in service delivery, with direct implications for the safety and quality of care delivered by health and community services.

Source and reference attributes

Submitting organisation:	Standards Australia

Origin:	National Health Data Committee National Community Services Data Committee Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Relational attributes

Related metadata references:	Supersedes Telephone number, version 2, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005.pdf (15.4 KB)
Implementation in Data Set Specifications:	Health care client identification Health, Superseded 04/05/2005

Telephone number type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (telephone)—telephone number type, code A
METeOR identifier:	270299
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005
Definition:	The type of telephone number recorded for a person, as represented by a code.
Data Element Concept:	Person (telephone)—telephone number type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A
Maximum character length:	1

Permissible values:

Value	Meaning
B	Business or work
H	Home
M	Personal mobile
N	Contact number (not own)
O	Business or work mobile
T	Temporary

Data element attributes

Collection and usage attributes

Guide for use:	Where more than one telephone number has been recorded, then each telephone number should have the appropriate telephone number type code assigned.
Comments:	Concerned with the use of person identification data. For organisations that create, use or maintain records on people. Organisations should use this standard, where appropriate, for collecting data when registering people. The positive and unique identification of people is a critical event in service delivery, with direct implications for the safety and quality of care delivered by health and community services.

Source and reference attributes

Submitting organisation:	Standards Australia

Origin:	National Health Data Committee National Community Services Data Committee
Reference documents:	Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Relational attributes

Related metadata references:	Supersedes Telephone number type, version 2, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005.pdf (15.5 KB)
Implementation in Data Set Specifications:	Health care client identification Health, Superseded 04/05/2005

Time C-reactive protein level measured

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—C-reactive protein level measured time, hhmm
Synonymous names:	CRP measured time
METeOR identifier:	343853
Registration status:	Health, Standard 01/10/2008
Definition:	The time the person's C-reactive protein (CRP) level is measured.
Data Element Concept:	Person—C-reactive protein level measured time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Collection methods:	The time C-reactive protein (CRP) is measured should be recorded from the laboratory report.

Relational attributes

Related metadata references:	See also Person—C-reactive protein level (measured), total milligrams per litre N[NN].N Health, Standard 01/10/2008 See also Person—C-reactive protein level measured date, DDMMYYYY Health, Standard 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Time creatine kinase MB isoenzyme measured

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatine kinase myocardial band isoenzyme measured time, hhmm
METeOR identifier:	285179
Registration status:	Health, Standard 04/06/2004
Definition:	The time at which the person's creatine kinase myocardial band (CK-MB) isoenzyme was measured.
Data Element Concept:	Person—creatine kinase myocardial band isoenzyme measured time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Guide for use:	Record the time in 24-hour clock format.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Time creatine kinase MB isoenzyme (CK-MB) measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.2 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008
	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005
	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Time of acute coronary syndrome related clinical event

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with acute coronary syndrome—acute coronary syndrome related clinical event time, hhmm
METeOR identifier:	349809
Registration status:	Health, Standard 01/10/2008
Definition:	The time a person experienced an acute coronary syndrome related clinical event.
Data Element Concept:	Person with acute coronary syndrome—acute coronary syndrome related clinical event time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Guide for use:	A time should be recorded for each of the specified clinical events that the person experiences.
Comments:	An acute coronary syndrome (ACS) related clinical event is a clinical event which can affect the health outcomes of a person with ACS. Information on the occurrence of these clinical events in people with ACS is required due to an emerging appreciation of their relationship with late mortality.

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome clinical event cluster Health, Standard 01/10/2008 *Conditional obligation:* If a clinical event has occurred, record the time when it was experienced by the person.

Time of diagnostic cardiac catheterisation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—diagnostic cardiac catheterisation time, hhmm
Synonymous names:	Time of coronary angiography
METeOR identifier:	359777
Registration status:	Health, Standard 01/10/2008
Definition:	The time when cardiac catheterisation is performed for diagnostic purposes.
Data Element Concept:	Person—diagnostic cardiac catheterisation time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item includes coronary angiography which is performed using a catheter.

Source and reference attributes

Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Time of electrocardiogram

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Electrocardiogram — electrocardiogram time, hhmm
Synonymous names:	Time of ECG
METeOR identifier:	343831
Registration status:	Health, Standard 01/10/2008
Definition:	The time at which an electrocardiogram (ECG) is performed for a person.
Data Element Concept:	Electrocardiogram — electrocardiogram time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Collection methods:	The time of ECG should be recorded irrespective of the setting (e.g. pre-hospital setting, emergency department or inpatient ward). The time of ECG should be recorded each time an ECG is performed.

Relational attributes

Implementation in Data Set Specifications:	Electrocardiogram cluster Health, Standard 01/10/2008

Time of implantable cardiac defibrillator procedure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—implantable cardiac defibrillator procedure time, hhmm
Synonymous names:	ICD procedure time
METeOR identifier:	359678
Registration status:	Health, Standard 01/10/2008
Definition:	The time when a procedure is performed for insertion of an implantable cardiac defibrillator (ICD).
Data Element Concept:	Person—implantable cardiac defibrillator procedure time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Source and reference attributes

Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Time of intra-aortic balloon pump procedure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—intra-aortic balloon pump procedure time, hhmm
METeOR identifier:	359691
Registration status:	Health, Standard 01/10/2008
Definition:	The time when a procedure is performed for insertion of an intra-aortic balloon pump.
Data Element Concept:	Person—intra-aortic balloon pump procedure time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Source and reference attributes

Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Time of intravenous fibrinolytic therapy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—intravenous fibrinolytic therapy time, hhmm
METeOR identifier:	360949
Registration status:	Health, Standard 01/10/2008
Definition:	The time intravenous (IV) fibrinolytic therapy was first administered to a person.
Data Element Concept:	Person—intravenous fibrinolytic therapy time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Guide for use:	If initiated by a bolus dose whether in a pre-hospital setting, emergency department or inpatient unit/ward, the time the initial bolus was administered should be recorded.
Comments:	This is used to calculate the time between initial presentation and reperfusion.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group

Relational attributes

Related metadata references:	Supersedes Person—intravenous fibrinolytic therapy time, hhmm Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008 *Conditional obligation:* If prescribed, provide the time when the fibrinolytic therapy is administered.

Time of non-invasive ventilation administration

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—non-invasive ventilation administration time, hhmm
METeOR identifier:	359647
Registration status:	Health, Standard 01/10/2008
Definition:	The time of administration of non-invasive ventilation.
Data Element Concept:	Person—non-invasive ventilation administration time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Source and reference attributes

Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Time of onset of acute coronary syndrome symptoms

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—acute coronary syndrome symptoms onset time, hhmm
METeOR identifier:	321211
Registration status:	Health, Standard 01/10/2008
Definition:	The time at which a person experienced acute coronary syndrome symptoms that prompted a person to seek medical attention, either at the hospital or from a general practitioner.
Data Element Concept:	Person—acute coronary syndrome symptoms onset time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Guide for use:

Acute coronary syndrome symptoms may include:

- tightness, pressure, heaviness, fullness or squeezing in the chest which may spread to the neck and throat, jaw, shoulders, the back, upper abdomen, either or both arms and even into the wrists and hands
- dyspnoea, nausea/vomiting, cold sweat or syncope.

Seeking medical attention could include the person presenting to their GP who then refers them to hospital or the person presenting directly to hospital (via ambulance or own form of transport).

If the person is already a patient at the hospital for another reason then the time recorded would be when they advised hospital staff of their symptoms.

Collection methods:

Record the time of onset of the most significant acute coronary syndrome symptom/s that prompted the person to seek medical attention (from the person's perspective).

Relational attributes

Related metadata references:	See also Person—acute coronary syndrome symptoms onset date, DDMMYYYY Health, Standard 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Time of pacemaker insertion

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—pacemaker insertion time, hhmm
METeOR identifier:	359662
Registration status:	Health, Standard 01/10/2008
Definition:	The time when a procedure is performed for insertion of a pacemaker.
Data Element Concept:	Person—pacemaker insertion time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Source and reference attributes

Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Time of primary percutaneous coronary intervention

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—primary percutaneous coronary intervention time, hhmm
Synonymous names:	Primary PCI time
METeOR identifier:	359201
Registration status:	Health, Standard 01/10/2008
Definition:	The time of the primary percutaneous coronary intervention (PCI).
Data Element Concept:	Person—primary percutaneous coronary intervention time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Guide for use:	Primary PCI relates to the first balloon angioplasty inflation and/or stent implantation for reperfusion therapy of a ST-segment-elevation myocardial infarction (STEMI). The time of the first balloon inflation should be recorded, even if this includes the implantation of a stent.
Comments:	This is used to calculate the time between initial presentation and reperfusion.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group

Relational attributes

Related metadata references:	Supersedes Person—first angioplasty balloon inflation or stenting time, hhmm Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Coronary artery cluster Health, Standard 01/10/2008 *Conditional obligation:* Record when a primary percutaneous coronary intervention is performed.

Time of rescue percutaneous coronary intervention

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—rescue percutaneous coronary intervention time, hhmm
Synonymous names:	Rescue PCI time
METeOR identifier:	359569
Registration status:	Health, Standard 01/10/2008
Definition:	The time when rescue percutaneous coronary intervention (PCI) is performed.
Data Element Concept:	Person—rescue percutaneous coronary intervention time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Guide for use:	Rescue PCI relates to balloon angioplasty inflation and/or stent implantation performed following failed fibrinolysis in patients with continuing or recurrent myocardial ischaemia.

Source and reference attributes

Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Implementation in Data Set Specifications:	Coronary artery cluster Health, Standard 01/10/2008 *Conditional obligation:* Record when a rescue percutaneous coronary intervention is performed.

Time of revascularisation percutaneous coronary intervention

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—revascularisation percutaneous coronary intervention time, hhmm
Synonymous names:	Revascularisation PCI time
METeOR identifier:	359738
Registration status:	Health, Standard 01/10/2008
Definition:	The time when a percutaneous coronary intervention (PCI) is performed for revascularisation.
Data Element Concept:	Person—revascularisation percutaneous coronary intervention time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Guide for use:	Revascularisation PCI relates to balloon angioplasty inflation and/or stent implantation performed for subsequent restoration of blood flow.
Comments:	Routine revascularisation PCI may be performed after ST-segment-elevation myocardial infarction for people with objective evidence of recurrent myocardial infarction in whom there is spontaneous or inducible ischaemia or haemodynamic instability. Revascularisation PCI may also be performed for treatment of high-risk non-ST-segment-elevation acute coronary syndrome.

Source and reference attributes

Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand
Reference documents:	National Heart Foundation of Australia & Cardiac Society of Australia and New Zealand. Guidelines for the management of

acute coronary syndromes 2006. Med J Aust 2006; 184; S1-S32. © MJA 2006

Relational attributes

Implementation in Data Set Specifications:

Coronary artery cluster Health, Standard 01/10/2008

Conditional obligation:
Record when a percutaneous coronary intervention is performed for revascularisation.

Time of triage

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—triage time, hhmm
METeOR identifier:	313817
Registration status:	Health, Standard 07/12/2005
Definition:	The time at which the patient is **triaged**.
Context:	Emergency Department care.
Data Element Concept:	Non-admitted patient emergency department service episode—triage time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Collection methods:	Collected in conjunction with non-admitted patient emergency department service episode—**triage** date.

Source and reference attributes

Submitting organisation:	Australian Government Department of Health and Ageing

Relational attributes

Related metadata references:	Supersedes Triage—triage time, hhmm Health, Superseded 07/12/2005
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008 Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008 Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Non-admitted patient emergency department care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Time of ventricular ejection fraction test

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Ventricular ejection fraction test—test time, hhmm
Synonymous names:	Time EF measured
METeOR identifier:	349817
Registration status:	Health, Standard 01/10/2008
Definition:	The time when a person's ventricular ejection fraction is measured.
Data Element Concept:	Ventricular ejection fraction—test time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Relational attributes

Implementation in Data Set Specifications:	Ventricular ejection fraction cluster Health, Standard 01/10/2008 *Conditional obligation:* To be provided when the ventricular ejection fraction is measured.

Time patient presents

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health service event—presentation time, hhmm
METeOR identifier:	270080
Registration status:	Health, Standard 01/03/2005
Definition:	The time at which the patient presents for the delivery of a service.
Data Element Concept:	Health service event—presentation time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

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 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 service commencement time).

Source and reference attributes

Submitting organisation:	National Institution Based Ambulatory Model Reference Group
Origin:	National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Time patient presents, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.2 KB)

Is used in the formation of Non-admitted patient emergency department service episode—waiting time (to service delivery), total minutes NNNNN Health, Superseded 22/12/2009

Is used in the formation of Non-admitted patient emergency department service episode—service episode length, total minutes NNNNN Health, Standard 01/03/2005

Is used in the formation of Non-admitted patient emergency department service episode—waiting time (to hospital admission), total hours and minutes NNNN Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Non-admitted patient emergency department care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Time troponin measured

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—troponin level measured time, hhmm
METeOR identifier:	359427
Registration status:	Health, Standard 01/10/2008
Definition:	The time at which the troponin (T or I) was measured.
Data Element Concept:	Person—troponin level measured time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item pertains to the measuring of troponin at any time point during this current event.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Person—troponin level measured time, hhmm Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Timing of ACE-inhibitor prescription

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—timing of ACE-inhibitor prescription, code N
METeOR identifier:	349385
Registration status:	Health, Standard 01/10/2008
Definition:	The timing of care when an ACE-inhibitor is prescribed to a person, as represented by a code.
Data Element Concept:	Person—timing of ACE-inhibitor prescription

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Prior to presentation at hospital
2	First 24 hours of presentation
3	After 24 hours and before discharge
4	At discharge

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Prior to presentation at hospital

Use this code when the person has been previously prescribed an ACE-inhibitor prior to presentation at the hospital and the person is still following the prescription.

CODE 2 First 24 hours of presentation

Use this code when an ACE-inhibitor is prescribed within the first 24 hours following presentation to the hospital.

CODE 3 After 24 hours and before discharge

Use this code when an ACE-inhibitor is prescribed following the first 24 hours after presentation to the hospital and before discharge from the hospital.

CODE 4 At discharge

Use this code when an ACE-inhibitor is prescribed at discharge from the hospital.

Collection methods: Record each time an ACE-inhibitor is prescribed for the person.

Relational attributes

Implementation in Data Set Specifications:

Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008

Conditional obligation:
If prescribed, provide a phase for each time ACE-inhibitor therapy is prescribed.

Timing of angiotensin II receptor blocker prescription

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—timing of angiotensin II receptor blocker prescription, code N
METeOR identifier:	350421
Registration status:	Health, Standard 01/10/2008
Definition:	The timing of care when an angiotensin II receptor blocker is prescribed to a person, as represented by a code.
Data Element Concept:	Person—timing of angiotensin II receptor blocker prescription

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Prior to presentation at hospital
	2	First 24 hours of presentation
	3	After 24 hours and before discharge
	4	At discharge
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Prior to presentation at hospital

Use this code when the person has been previously prescribed an angiotensin II receptor blocker prior to presentation at the hospital and the person is still following the prescription.

CODE 2 First 24 hours of presentation

Use this code when an angiotensin II receptor blocker is prescribed within the first 24 hours following presentation to the hospital.

CODE 3 After 24 hours and before discharge

Use this code when an angiotensin II receptor blocker is prescribed following the first 24 hours after presentation to the hospital and before discharge from the hospital.

CODE 4 At discharge

Use this code when an angiotensin II receptor blocker is prescribed at discharge from the hospital.

Collection methods:

Record each time an angiotensin II receptor blocker is prescribed for the person.

Relational attributes

Implementation in Data Set Specifications:

Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008

Conditional obligation:
If prescribed, provide a phase for each time angiotensin II receptor blocker therapy is prescribed.

Timing of antithrombin therapy prescription

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—timing of antithrombin therapy prescription, code N
METeOR identifier:	350510
Registration status:	Health, Standard 01/10/2008
Definition:	The timing of care when antithrombin therapy is prescribed to a person, as represented by a code.
Data Element Concept:	Person—timing of antithrombin therapy prescription

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Initial medical management: preceding reperfusion therapy
2	During reperfusion therapy
3	Following reperfusion therapy

Supplementary values:

9	Not stated/inadequately described

Source and reference attributes

Reference documents: National Heart Foundation of Australia and Cardiac Society of Australia and New Zealand, Guidelines for the management of acute coronary syndromes 2006, Med J Aust; 184; S1-S32.

Data element attributes

Collection and usage attributes

Guide for use:

Reperfusion therapy includes percutaneous coronary intervention and fibrinolytic therapy.

CODE 1 Initial medical management: preceding reperfusion therapy

Use this code when antithrombin therapy is prescribed before reperfusion therapy is to be performed.

CODE 2 During reperfusion therapy

Use this code when antithrombin therapy is prescribed while reperfusion therapy is being performed.

CODE 3 Following reperfusion therapy

Use this code when antithrombin therapy is prescribed after reperfusion therapy has been performed.

Collection methods:

Record for each time antithrombin therapy is prescribed for the person.

Relational attributes

Implementation in Data Set Specifications:

Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008

Conditional obligation:
If prescribed, provide a phase for each time antithrombin therapy is prescribed

Timing of aspirin prescription

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—timing of aspirin prescription, code N
METeOR identifier:	347829
Registration status:	Health, Standard 01/10/2008
Definition:	The timing of care when aspirin is prescribed to a person, as represented by a code.
Data Element Concept:	Person—timing of aspirin prescription

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Prior to presentation at hospital
2	First 24 hours of presentation
3	After 24 hours and before discharge
4	At discharge

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Prior to presentation at hospital

Use this code when the person has been previously prescribed aspirin prior to presentation at the hospital and the person is still following the prescription.

CODE 2 First 24 hours of presentation

Use this code when aspirin is prescribed within the first 24 hours following presentation to the hospital.

CODE 3 After 24 hours and before discharge

Use this code when aspirin is prescribed following the first 24 hours after presentation to the hospital and before discharge from the hospital.

CODE 4 At discharge

Use this code when aspirin is prescribed at discharge from the hospital.

Collection methods: Record each time aspirin is prescribed for the person.

Relational attributes

Implementation in Data Set Specifications:

Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008

Conditional obligation:
If prescribed, provide a phase for each time aspirin therapy is prescribed.

Timing of beta-blocker prescription

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—timing of beta-blocker prescription, code N
METeOR identifier:	349400
Registration status:	Health, Standard 01/10/2008
Definition:	The timing of care when a beta-blocker is prescribed to a person, as represented by a code.
Data Element Concept:	Person—timing of beta-blocker prescription

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Prior to presentation at hospital
	2	First 24 hours of presentation
	3	After 24 hours and before discharge
	4	At discharge
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Prior to presentation at hospital

Use this code when the person has been previously prescribed a beta-blocker prior to presentation at the hospital and the person is still following the prescription.

CODE 2 First 24 hours of presentation

Use this code when a beta-blocker is prescribed within the first 24 hours following presentation to the hospital.

CODE 3 After 24 hours and before discharge

Use this code when a beta-blocker is prescribed following the first 24 hours after presentation to the hospital and before discharge from the hospital.

CODE 4 At discharge

Use this code when a beta-blocker is prescribed at discharge from the hospital.

Collection methods: Record each time a beta-blocker is prescribed for a person.

Relational attributes

Implementation in Data Set Specifications:

Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008

Conditional obligation:
If prescribed, provide a phase for each time beta-blocker therapy is prescribed.

Timing of clopidogrel prescription

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—timing of clopidogrel prescription, code N
METeOR identifier:	350431
Registration status:	Health, Standard 01/10/2008
Definition:	The timing of care when clopidogrel is prescribed to a person, as represented by a code.
Data Element Concept:	Person—timing of clopidogrel prescription

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Prior to presentation at hospital
2	First 24 hours of presentation
3	After 24 hours and before discharge
4	At discharge

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Prior to presentation at hospital

Use this code when the person has been previously prescribed clopidogrel prior to presentation at the hospital and the person is still following the prescription.

CODE 2 First 24 hours of presentation

Use this code when clopidogrel is prescribed within the first 24 hours following presentation to the hospital.

CODE 3 After 24 hours and before discharge

Use this code when clopidogrel is prescribed following the first 24 hours after presentation to the hospital and before discharge from the hospital.

CODE 4 At discharge

Use this code when clopidogrel is prescribed at discharge from the hospital.

Collection methods: Record each time clopidogrel is prescribed for the person.

Relational attributes

Implementation in Data Set Specifications:

Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008

Conditional obligation:
If prescribed, provide a phase for each time clopidogrel therapy is prescribed.

Timing of glycoprotein IIb/IIIa inhibitor prescription

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—timing of glycoprotein IIb/IIIa inhibitor prescription, code N
METeOR identifier:	349367
Registration status:	Health, Standard 01/10/2008
Definition:	The timing of care when a glycoprotein IIb/IIIa inhibitor is prescribed to a person, as represented by a code.
Data Element Concept:	Person—timing of glycoprotein IIb/IIIa inhibitor prescription

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Initial medical management: preceding invasive management
2	During invasive management
3	Following invasive management

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

Invasive management includes angiography, percutaneous coronary intervention and coronary artery bypass graft.

CODE 1 Initial medical management: preceding invasive management

Use this code when a glycoprotein IIb/IIIa inhibitor is prescribed before invasive management is to be performed.

CODE 2 During invasive management

Use this code when a glycoprotein IIb/IIIa inhibitor is prescribed while invasive management is being performed.

CODE 2 Following invasive management

Use this code when a glycoprotein IIb/IIIa inhibitor is prescribed after invasive management has been performed.

Collection methods:

Record each time a glycoprotein IIb/IIIa inhibitor is prescribed for a person.

Relational attributes

Implementation in Data Set Specifications:

Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008

Conditional obligation:
If prescribed, provide a phase for each time glycoprotein IIb/IIIa inhibitor therapy is prescribed.

Timing of statin prescription

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—timing of statin prescription, code N
METeOR identifier:	350445
Registration status:	Health, Standard 01/10/2008
Definition:	The timing of care when a statin is prescribed to a person, as represented by a code.
Data Element Concept:	Person—timing of statin prescription

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Prior to presentation at hospital
2	First 24 hours of presentation
3	After 24 hours and before discharge
4	At discharge

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Prior to presentation at hospital

Use this code when the person has been previously prescribed a statin prior to presentation at the hospital and the person is still following the prescription.

CODE 2 First 24 hours of presentation

Use this code when a statin is prescribed for within the first 24 hours following presentation to the hospital.

CODE 3 After 24 hours and before discharge

Use this code when an ACE-inhibitor is prescribed following the first 24 hours after presentation to the hospital and before discharge from the hospital.

CODE 4 At discharge

Use this code when a statin is prescribed at discharge from the hospital.

Collection methods: Record each time a statin is prescribed for the person.

Relational attributes

Implementation in Data Set Specifications:

Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008

Conditional obligation:
If prescribed, provide a phase for each time statin therapy is prescribed.

Tobacco smoking indicator, after 20 weeks of pregnancy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female (pregnant)—tobacco smoking indicator (after twenty weeks of pregnancy), yes/no code N
METeOR identifier:	365417
Registration status:	Health, Standard 03/12/2008
Definition:	A self-reported indicator of whether a pregnant woman smoked tobacco at any time after the first 20 weeks of her pregnancy until the birth, as represented by a code
Context:	Perinatal Statistics
Data Element Concept:	Female (pregnant)—tobacco smoking indicator (after twenty weeks of pregnancy)

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes Record if a woman smoked tobacco at any time after the first 20 weeks of pregnancy. CODE 2 No Record if a woman did not smoke tobacco at any time after the first 20 weeks of pregnancy.
Collection methods:	Recommended question: 'Did the woman smoke at all after 20 weeks of pregnancy?', where after 20 weeks of pregnancy is defined as greater than or equal to 20 weeks + 0 days. To ensure consistency of results, data should be collected after delivery.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: See also Female (pregnant) – tobacco smoking indicator (first twenty weeks of pregnancy), yes/no code N Health, Standard 03/12/2008

Implementation in Data Set Specifications: Perinatal NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Tobacco smoking indicator, first 20 weeks of pregnancy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female (pregnant)—tobacco smoking indicator (first twenty weeks of pregnancy), yes/no code N
METeOR identifier:	365404
Registration status:	Health, Standard 03/12/2008
Definition:	A self-reported indicator of whether a pregnant woman smoked tobacco at any time during the first 20 weeks of her pregnancy, as represented by a code
Context:	Perinatal Statistics
Data Element Concept:	Female (pregnant)—tobacco smoking indicator (first twenty weeks of pregnancy)

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 9 Not stated/inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes

Record if a woman smoked tobacco at any time during the first 20 weeks of pregnancy.

CODE 2 No

Record if a woman did not smoke tobacco at any time during the first 20 weeks of pregnancy.

Collection methods:

Recommended question: 'Did the woman smoke at all during the first 20 weeks of pregnancy?', where the first 20 weeks of pregnancy is defined as less than or equal to 19 weeks + 6 days.

To ensure consistency of results, data should be collected after the first 20 weeks of pregnancy.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: See also Female (pregnant)—number of cigarettes smoked (per day after 20 weeks of pregnancy), number N[NN] Health, Standard 03/12/2008

See also Female (pregnant)—tobacco smoking indicator (after twenty weeks of pregnancy), yes/no code N Health, Standard 03/12/2008

Implementation in Data Set Specifications: Perinatal NMDS 2010-2011 Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Tobacco smoking status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—tobacco smoking status, code N
METeOR identifier:	270311
Registration status:	Health, Standard 01/03/2005
Definition:	A person's current and past smoking behaviour, as represented by a code.
Context:	Public health and health care
Data Element Concept:	Person—tobacco smoking status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

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

Collection and usage attributes

Guide for use:

CODE 1 Daily smoker

A person who smokes daily

CODE 2 Weekly smoker

A person who smokes at least weekly but not daily

CODE 3 Irregular smoker

A person who smokes less than weekly

CODE 4 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.

CODE 5 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.

Source and reference attributes

Reference documents: Standard Questions on the Use of Tobacco Among Adults (1998)

Data element attributes

Collection and usage attributes

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 years and over.

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' smoker 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.

Smoker type is used to define subpopulations 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

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.

Relational attributes

Related metadata references: Supersedes Tobacco smoking status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.5 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Tobacco smoking status (diabetes mellitus)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—regular tobacco smoking indicator (last 3 months), code N
METeOR identifier:	302467
Registration status:	Health, Standard 21/09/2005
Definition:	Whether an individual has been a regular smoker (daily or weekly) of any tobacco material over the previous 3 months, as represented by a code.
Data Element Concept:	Person—regular tobacco smoking indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described
	This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes: Record if the person has smoked daily or weekly over the previous 3 months.
	CODE 2 No: Record if the person has not smoked daily or weekly over the previous 3 months or has been an irregular smoker.
Collection methods:	Ask the individual if he/she has regularly smoked (daily or weekly) any tobacco material over the past 3 months.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:	Supersedes Person—tobacco smoking status (previous three months), code N Health, Superseded 21/09/2005
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Standard 21/09/2005

Tobacco smoking—consumption/quantity (cigarettes)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—number of cigarettes smoked (per day), total N[N]
METeOR identifier:	270332
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of cigarettes (manufactured or roll-your-own) smoked per day by a person.
Context:	Public health and health care
Data Element Concept:	Person—number of cigarettes smoked

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	N[N]	
Maximum character length:	2	
Supplementary values:	Value	Meaning
	99	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item 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 recorded as 98.
Collection methods:	The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults (1998) - interviewer administered (Questions 3a and 3b) and self-administered (Questions 2a and 2b) versions. The questions cover persons aged 18 and over.
Comments:	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)
- monitor health risk factors and progress towards National Health
  Goals and Targets
- ascertain determinants and consequences of smoking
- assess a person's exposure to tobacco smoke.

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.

Relational attributes

Related metadata references:

Supersedes Tobacco smoking - consumption/quantity (cigarettes), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.7 KB)

Implementation in Data Set Specifications:

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Tobacco smoking—duration (daily smoking)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—tobacco smoking duration (daily smoking), total years N[N]
METeOR identifier:	270330
Registration status:	Health, Standard 01/03/2005
Definition:	The total 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
Data Element Concept:	Person—tobacco smoking duration

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	N[N]	
Maximum character length:	2	
Supplementary values:	Value	Meaning
	99	Not stated/inadequately described
Unit of measure:	Year	

Data element attributes

Collection and usage attributes

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 (1998) - interviewer administered (Question 1, 5, 6, 7) and self-administered (Question 1, 3, 3a, 4) versions. The questions cover persons aged 18 years and over.
Comments:	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.

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.

Relational attributes

Related metadata references:

Supersedes Tobacco smoking - duration (daily smoking), version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.7 KB)

Is formed using Person—tobacco smoking start age (daily smoking), total years NN Health, Standard 01/03/2005

Is formed using Person—tobacco smoking quit age (daily smoking), total years NN Health, Standard 01/03/2005

Tobacco smoking—ever daily use

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—tobacco smoking daily use status, code N
METeOR identifier:	270329
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of whether a person has ever smoked tobacco in any form on a daily basis in their lifetime, as represented by a code.
Data Element Concept:	Person—tobacco smoking daily use status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Ever-daily
2	Never-daily

Collection and usage attributes

Guide for use:

CODE 1 Ever-daily

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).

CODE 2 Never-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).

Data element attributes

Collection and usage attributes

Collection methods:	The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults (1998) - interviewer administered (Question 1 and 5) and self-administered (Question 1 and 3) versions. The questions cover persons aged 18 years and over.
Comments:	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);
- monitor health risk factors;
- ascertain determinants and consequences of smoking.

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.

Relational attributes

Related metadata references:

Supersedes Tobacco smoking - ever daily use, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.0 KB)

Tobacco smoking—frequency

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—tobacco smoking frequency, code N
METeOR identifier:	270328
Registration status:	Health, Standard 01/03/2005
Definition:	How often a person now smokes a tobacco product, as represented by a code.
Data Element Concept:	Person—tobacco smoking frequency

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

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

Data element attributes

Collection and usage attributes

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 (1998) - 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 years and over.
Comments:	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).

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.

Relational attributes

Related metadata references:

Supersedes Tobacco smoking - frequency, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.7 KB)

Tobacco smoking—product

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—tobacco product smoked, code N
METeOR identifier:	270327
Registration status:	Health, Standard 01/03/2005
Definition:	The type of tobacco product smoked by a person, as represented by a code.
Data Element Concept:	Person—tobacco product smoked

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

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

Data element attributes

Collection and usage attributes

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 (1998) - interviewer or self-administered versions.
Comments:	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.

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.

Relational attributes

Related metadata references:

Supersedes Tobacco smoking - product, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.1 KB)

Tobacco smoking—quit age (daily smoking)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—tobacco smoking quit age (daily smoking), total years NN
METeOR identifier:	270323
Registration status:	Health, Standard 01/03/2005
Definition:	The 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
Data Element Concept:	Person—tobacco smoking quit age

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	String	
Format:	NN	
Maximum character length:	2	
Supplementary values:	Value	Meaning
	99	Not stated/inadequately described
Unit of measure:	Year	

Data element attributes

Collection and usage attributes

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 years and over. The relevant question in each version of the questionnaires refers to when the person finally stopped smoking daily, whereas the definition for this metadata item 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.

Comments:

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

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.

Relational attributes

Related metadata references:

Supersedes Tobacco smoking - quit age (daily smoking), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.8 KB)

Is used in the formation of Person—time since quitting tobacco smoking (daily smoking), code NN Health, Standard 01/03/2005

Is used in the formation of Person—tobacco smoking duration (daily smoking), total years N[N] Health, Standard 01/03/2005

Tobacco smoking—start age (daily smoking)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—tobacco smoking start age (daily smoking), total years NN
METeOR identifier:	270324
Registration status:	Health, Standard 01/03/2005
Definition:	The 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
Data Element Concept:	Person—tobacco smoking start age

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	String	
Format:	NN	
Maximum character length:	2	
Supplementary values:	Value	Meaning
	99	Not stated/inadequately described
Unit of measure:	Year	

Data element attributes

Collection and usage attributes

Guide for use:	Record age in completed years. 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 (1998) - interviewer administered (Question 7) and self-administered (Question 4) versions. The questions cover persons aged 18 years and over.
Comments:	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. 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: 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.

Relational attributes

Related metadata references:

Supersedes Tobacco smoking - start age (daily smoking), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.7 KB)

Is used in the formation of Person—tobacco smoking duration (daily smoking), total years N[N] Health, Standard 01/03/2005

Tobacco smoking—time since quitting (daily smoking)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—time since quitting tobacco smoking (daily smoking), code NN
METeOR identifier:	270356
Registration status:	Health, Standard 01/03/2005
Definition:	The time since a person most recently quit daily smoking, as represented by a code.
Context:	Public health and health care
Data Element Concept:	Person—time since quitting tobacco smoking

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
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

Supplementary values:

Value	Meaning
99	not stated

Data element attributes

Collection and usage attributes

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, then code 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 (1998) - interviewer administered (Question 6) and self-administered (Question 3) versions.

Comments:

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.

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.

Relational attributes

Related metadata references:

Supersedes Tobacco smoking - time since quitting (daily smoking), version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.0 KB)

Is formed using Person—tobacco smoking quit age (daily smoking), total years NN Health, Standard 01/03/2005

Total blood units transfused

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—units of blood transfused, total N[NNN]
METeOR identifier:	344798
Registration status:	Health, Standard 01/10/2008
Definition:	The total number of units of blood that a person has received, either whole blood or packed red blood cells.
Data Element Concept:	Person—units of blood transfused

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
9999	Not stated/inadequately described

Collection and usage attributes

Guide for use: 1 blood unit (or one bag of blood) = approx 500ml of blood

Data element attributes

Collection and usage attributes

Guide for use: Platelet transfusions or transfusions of fresh frozen plasma (FFP) should not be included in the total.

Relational attributes

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Conditional obligation:
Record the total number of blood units (either whole blood or packed red blood cells) that the person has received following a haemorrhagic event.

Total contract patient days

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Admitted patient hospital stay—number of patient days (of contracted care), total N[NN]
METeOR identifier:	270301
Registration status:	Health, Standard 01/03/2005
Definition:	Sum of the number of contract patient days for all periods within the hospital stay.
Data Element Concept:	Admitted patient hospital stay—number of patient days (of contracted care)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:

Count number of days.

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.

Relational attributes

Related metadata references:

Supersedes Total contract patient days, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.9 KB)

Total leave days

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—number of leave days, total N[NN]
METeOR identifier:	270251
Registration status:	Health, Standard 01/03/2005
Definition:	Sum of the length of leave (date returned from leave minus date went on leave) for all periods within the hospital stay.
Data Element Concept:	Episode of admitted patient care—number of leave days

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Day

Data element attributes

Collection and usage attributes

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.

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 metadata item was modified in July 1996 to exclude the previous differentiation between the psychiatric and other patients.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Total leave days, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.6 KB)

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v 6) NN Health, Standard 22/12/2009

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v 6) ANNA Health, Standard 22/12/2009

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA Health, Superseded 22/12/2009

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN Health, Superseded 22/12/2009

Is used in the formation of Episode of admitted patient care—length of stay (excluding leave days), total N[NN] Health, Standard 01/03/2005

Is used in the formation of Episode of care—number of psychiatric care days, total N[NNNN] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Total psychiatric care days

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—number of psychiatric care days, total N[NNNN]
METeOR identifier:	270300
Registration status:	Health, Standard 01/03/2005
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.
Data Element Concept:	Episode of care—number of psychiatric care days

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNN]
Maximum character length:	5
Unit of measure:	Day

Data element attributes

Collection and usage attributes

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 (Commonwealth) (now licensed/approved by each State/Territory health authority), catering primarily for patients with psychiatric or behavioural disorders are included in this category.

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 nursing homes. 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 metadata item 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 metadata item Care type. Total psychiatric care days may cover one or more periods in a designated psychiatric unit within the overall

hospital stay.

Collection methods:

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.

Comments:

This metadata item 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 metadata item is intended to improve understanding in this area and contribute to the ongoing evaluation of changes occurring in mental health services.

Source and reference attributes

Submitting organisation: National Mental Health Information Strategy Committee

Reference documents: Health Insurance Act 1973 (Commonwealth)

Relational attributes

Related metadata references:

Supersedes Total psychiatric care days, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (23.8 KB)

Is formed using Establishment—establishment type, sector and services provided code AN.N{.N} Health, Standard 01/03/2005

Is formed using Hospital service—care type, code N[N].N Health, Standard 01/03/2005

Is formed using Episode of admitted patient care—number of leave days, total N[NN] Health, Standard 01/03/2005

Is formed using Episode of admitted patient care—admission date, DDMMYYYY Health, Standard 01/03/2005

Is formed using Episode of admitted patient care—separation date, DDMMYYYY Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Treatment delivery setting for alcohol and other drugs

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—service delivery setting, code N
METeOR identifier:	270068
Registration status:	Health, Standard 01/03/2005
Definition:	The main physical setting in which the type of treatment that is the principal focus of a client's alcohol and other drug treatment episode is actually delivered irrespective of whether or not this is the same as the usual location of the service provider, as represented by a code.
Data Element Concept:	Episode of treatment for alcohol and other drugs—service delivery setting

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Non-residential treatment facility
2	Residential treatment facility
3	Home
4	Outreach setting
8	Other

Collection and usage attributes

Guide for use:

Only one code to be selected at the end of the alcohol and other drug treatment episode. Agencies should report the setting in which most of the main type of treatment was received by the client during the treatment episode.

CODE 1 Non-residential treatment facility

This code refers to any non-residential centre that provides alcohol and other drug treatment services, including hospital outpatient services and community health centres.

CODE 2 Residential treatment facility

This code 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, but does include therapeutic community settings.

CODE 3 Home

This code refers to the client's own home or usual place of residence.

CODE 4 Outreach setting

This code 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.

Data element attributes

Source and reference attributes

Submitting organisation: Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references: Supersedes Treatment delivery setting for alcohol and other drugs, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.8 KB)

Implementation in Data Set Specifications:

Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Alcohol and other drug treatment services NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Triage category

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—triage category, code N
METeOR identifier:	390392
Registration status:	Health, Standard 22/12/2009
Definition:	The urgency of the patient's need for medical and nursing care as assessed at triage, as represented by a code.
Data Element Concept:	Non-admitted patient emergency department service episode—triage category

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
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

Data element attributes

Collection and usage attributes

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, both triage categories can be captured, but the original category must be reported in this data element.

Source and reference attributes

Origin:	National Triage Scale, Australasian College for Emergency Medicine

Relational attributes

Related metadata references:	Supersedes Non-admitted patient emergency department service episode—triage category, code N Health, Superseded 22/12/2009
Implementation in Data Set Specifications:	Non-admitted patient emergency department care NMDS 2010-2011 Health, Standard 22/12/2009 *Implementation start date:* 01/07/2010

Triglyceride level (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—triglyceride level (measured), total millimoles per litre N[N].N
METeOR identifier:	359411
Registration status:	Health, Standard 01/10/2008
Definition:	A person's triglyceride level measured in millimoles per litre.
Data Element Concept:	Person—triglyceride level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N].N
Maximum character length:	3

Supplementary values:

Value	Meaning
99.9	Not stated/inadequately described.

Unit of measure: Millimole per litre (mmol/L)

Data element attributes

Collection and usage attributes

Guide for use: Record the absolute result of the total triglyceride measurement.

Collection methods: Measurement of lipid levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authorities.

- To be collected as a single venous blood sample, preferably following a 12-hour fast where only water and medications have been consumed.

Note that to calculate the low-density lipoprotein - cholesterol (LDL-C) from the Friedwald Equation (Friedwald et al, 1972):

- a fasting level of plasma triglyceride and knowledge of the levels of plasma total cholesterol and high-density lipoprotein - cholesterol (HDL-C) is required,
- the Friedwald equation becomes unreliable when the plasma triglyceride exceeds 4.5 mmol/L, and
- that while levels are reliable for the first 24 hours after the onset of acute coronary syndromes, they may be unreliable for the subsequent 8 weeks after an event.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Relational attributes

Related metadata references:	Supersedes Person—triglyceride level (measured), total millimoles per litre N[N].N Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008
	Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Troponin assay type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—troponin assay type, code N
METeOR identifier:	356929
Registration status:	Health, Standard 01/10/2008
Definition:	The type of troponin assay (I or T) used to assess the person's troponin levels, as represented by a code.
Data Element Concept:	Person—troponin assay type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Cardiac troponin T (cTnT)
2	Cardiac troponin I (cTnI)

Supplementary values:

9	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group.
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Person—troponin assay type, code N Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Troponin assay—upper limit of normal range (micrograms per litre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for troponin assay, total micrograms per litre N[NNN]
METeOR identifier:	359315
Registration status:	Health, Standard 01/10/2008
Definition:	Laboratory standard for the value of 'troponin T' or 'troponin I' measured in micrograms per litre that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range of troponin assay

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
9998	Not measured
9999	Not stated/inadequately described

Unit of measure:	Microgram per litre (µg/L)

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of normal (usually the ninety-ninth percentile of a normal population) for the individual laboratory.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group

Relational attributes

Related metadata references:	Supersedes Laboratory standard—upper limit of normal range for troponin assay, total micrograms per litre N[NNN] Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Troponin level (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—troponin level (measured), total micrograms per litre NN.NN
METeOR identifier:	356934
Registration status:	Health, Standard 01/10/2008
Definition:	A person's troponin measured in micrograms per litre.
Data Element Concept:	Person—troponin level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NN.NN
Maximum character length:	4

Supplementary values:

Value	Meaning
88.88	Not measured
99.99	Not stated/inadequately described

Unit of measure: Microgram per litre (µg/L)

Collection and usage attributes

Guide for use: CODE 88.88 Not measured

This code is used if test for troponin (T or I) was not done.

Data element attributes

Collection and usage attributes

Guide for use: Measured in different assays dependant upon laboratory methodology.

When only one troponin level is recorded, this should be the peak level.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references: See also Laboratory standard—upper limit of normal range for troponin assay, total micrograms per litre N[NNN] Health, Superseded 01/10/2008

	Supersedes Person—troponin level (measured), total micrograms per litre NN.NN Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Tumour size at diagnosis (solid tumours)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—solid tumour size (at diagnosis), total millimetres NNN
METeOR identifier:	370042
Registration status:	Health, Standard 06/03/2009
Definition:	The largest dimension of a solid tumour, measured in millimetres.
Data Element Concept:	Person with cancer—solid tumour size

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	String
Format:	NNN
Maximum character length:	3
Supplementary values:	Value Meaning 999 Unknown
Unit of measure:	Millimetre (mm)

Collection and usage attributes

Guide for use:	Size in millimetres with valid values 001 to 997.

Data element attributes

Collection and usage attributes

Guide for use:

The reporting standard for the size of solid tumours is:

Breast cancer or other solid neoplasms - the largest tumour dimension, measured to a precision of 1mm.

Round to the nearest millimetre, rounding up if size is ≥ .5 mm (e.g. 1.50mm, 1.54mm recorded as 2mm, 1.47mm recorded as 1mm).

General coding rules:

Recorded size:

Only record measured size if stated, otherwise record size as unknown. Do not attempt to estimate size from descriptions of the tumour, such as 'tumour occupying three quarters of tissue'.

Do not take values for size from sources other than histopathology (such as imaging, mammography or clinical examination).

Size reported for multiple specimens:

If tumour is removed in more than one procedure (e.g. biopsy and excision, local excision and re-excision) do not sum the sizes across multiple pathology reports but rather use the larger of the measured sizes from the separate pathology reports.

If tumour is divided into several parts (in the same pathology report), do not sum sizes together but rather use the larger of the measured sizes. However, if the pathologist states an aggregate or composite size, record that size.

Multifocal tumour:

If the tumour is multifocal, record the size of the largest measured focus. Do not attempt to sum sizes of different foci.

Macroscopic size:

If only macroscopic size is given, record this value.

If the macroscopic and microscopic measurements differ, the microscopic measurement should be recorded.

Exclusions:

Size is not recorded for Phyllodes tumours, sarcomas, or lymphomas.

Invasive breast cancer coding rules:

Note: These rules are to be used only when the record pertains to an invasive breast cancer (as per Person with cancer-primary site of cancer, code (ICDO-3), ANN{.N[N]}).

Invasive tumours with an in situ component:

When an invasive tumour contains an in situ component, only record the size of the invasive component as stated.

If the size of the invasive tumour is not recorded separately to the in-situ component, then record the total size of the tumour without any attempt to estimate the invasive component using percentage or size of the in situ component.

Microinvasive tumour:

For microinvasive tumours, record size in millimetres if stated. If microinvasion is stated but no size is recorded, enter 990 in size field to enable these very small tumours to be differentiated from other tumours without measured sizes.

Bilateral breasts tumours:

Bilateral tumours are recorded as two separate primary tumours each having their own size (and other data elements).

Multifocal tumours with different morphology:

Foci with different morphology should be considered to be separate primary tumours each having their own size (and other data elements). The coder needs to ascertain whether two foci with differing morphology are separate primaries with different morphology or a single multifocal primary with a mixed histology. In the latter case the rule of taking the size from the larger focus would apply as stated.

Collection methods:

This data item is collected for the size of tumours as specified in pathology reports.

Source and reference attributes

Reference documents:

Johnson CH, Adamo M (eds.). SEER Program Coding and Staging Manual 2007. National Cancer Institute, NIH Publication number 07-5581, Bethesda, MD 2007.

National Breast and Ovarian Cancer Centre and Australian Cancer Network. The Pathology reporting of breast cancer. A guide for pathologists, surgeons, radiologists and oncologists (3rd edition). National Breast and Ovarian Cancer Centre, Surry Hills, NSW, 2008.

Relational attributes

Related metadata references:

Supersedes Person with cancer—solid tumour size (at diagnosis), total millimetres NNN Health, Superseded 06/03/2009

Is used in the formation of Person with cancer—primary tumour status, T stage (UICC TNM Classification of Malignant Tumours, 6th ed) code XX[X] Health, Standard 06/03/2009

Implementation in Data Set Specifications:

Breast cancer (Cancer registries) DSS Health, Standard 06/03/2009

Cancer (clinical) DSS Health, Superseded 22/12/2009

Cancer (clinical) DSS Health, Standard 22/12/2009

Tumour thickness at diagnosis (melanoma)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—melanoma thickness (at diagnosis), total millimetres NNN.NN
METeOR identifier:	270185
Registration status:	Health, Standard 01/03/2005
Definition:	The measured thickness of a melanoma in millimetres.
Data Element Concept:	Person with cancer—melanoma thickness

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	String
Format:	NNN.NN
Maximum character length:	5

Supplementary values:

Value	Meaning
999.99	Unknown

Unit of measure: Millimetre (mm)

Data element attributes

Collection and usage attributes

Guide for use:

The reporting standard for the thickness of melanoma is:

Primary cutaneous melanoma - the depth of penetration of tumour cells below the basal layer of the skin; measured to a precision of 0.01mm.

Size in millimetres - valid values are: 000.01 to 997.99

Relational attributes

Related metadata references: Supersedes Tumour thickness at diagnosis - melanoma, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.3 KB)

Implementation in Data Set Specifications:

Cancer (clinical) DSS Health, Superseded 07/12/2005

Cancer (clinical) DSS Health, Superseded 06/03/2009

Cancer (clinical) DSS Health, Superseded 22/12/2009

Cancer (clinical) DSS Health, Standard 22/12/2009

Type of accommodation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—accommodation type (usual), code N[N]
METeOR identifier:	270088
Registration status:	Health, Standard 01/03/2005
Definition:	The type of accommodation setting in which a person usually lives/lived, as represented by a code.
Context:	Admitted patient mental health care: Permits analysis of the usual residential accommodation type of people prior to admission to institutional 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.
Data Element Concept:	Person—accommodation type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
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 disability)
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
Supplementary values:	14	Unknown/unable to determine

Collection and usage attributes

Guide for use:

CODE 3 Residential aged care service

Includes nursing home beds in acute care hospitals.

CODE 4 Specialised alcohol/other drug treatment residence

Includes alcohol/other drug treatment units in psychiatric hospitals.

CODE 5 Specialised mental health community-based residential support service

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.

CODE 6 Domestic-scale supported living facility (e.g. group home for people with disability)

Domestic-scale supported living facilities include group homes for people with disability, 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.

CODE 10 Other supported accommodation

Includes other supported accommodation facilities such as hostels for people with disability and Residential Services/Facilities (Victoria and South Australia only). These facilities provide board and lodging and rostered care workers provide client support services.

Data element attributes

Collection and usage attributes

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 institutional 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 to questioning about a person's usual accommodation setting 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.

Comments:

The changes made to this metadata item 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. Home and Community Care Data Dictionary Version 1 and National Community Services Data Dictionary Version 1).

Relational attributes

Related metadata references:

Supersedes Type of accommodation, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.4 KB)

Implementation in Data Set Specifications:

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Type of augmentation of labour

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—labour augmentation type, code N
METeOR identifier:	270036
Registration status:	Health, Standard 01/03/2005
Definition:	Methods used to assist progress of labour, as represented by a code.
Data Element Concept:	Birth event—labour augmentation type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
0	None
1	Oxytocin
2	Prostaglandins
3	Artificial rupture of membranes (ARM)
4	Other
5	Not stated

Supplementary values:

Collection and usage attributes

Comments: Prostaglandin is listed as a method of augmentation in the data domain. Advice from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists 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.

Data element attributes

Collection and usage attributes

Guide for use: More than one method of augmentation can be recorded, except where 0=none applies.

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.

Comments: 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.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Type of augmentation of labour, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.4 KB)

Type of health or health related function

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Organisation—type of health or health related function, code NNN
METeOR identifier:	352187
Registration status:	Health, Standard 05/12/2007
Definition:	Describes the type of activities or programs with a health or health-related function provided by an organisation, as represented by a code.
Data Element Concept:	Organisation—type of health or health related function

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	NNN
Maximum character length:	3

Permissible values:

Value	Meaning
101	Admitted patient care – Mental health program
102	Admitted patient care – Non-Mental health program
199	Admitted patient care – Not further defined
201	Residential care – Mental health program
202	Residential care – Non-Mental health program
299	Residential care – Not further defined
301	Ambulatory care – Mental health program
302	Ambulatory care – Emergency department
303	Ambulatory care – General practitioner
304	Ambulatory care – Medical specialist
305	Ambulatory care – Imaging/pathology
306	Ambulatory care – Dental service
307	Ambulatory care – Optometry service
308	Ambulatory care – Allied health service
309	Ambulatory care – Community health service
388	Ambulatory care – Other
399	Ambulatory care – Not further defined
401	Public health – Communicable disease control
402	Public health – Selected health promotion
403	Public health – Organised immunisation

404	Public health – Environmental health
405	Public health – Food standards and hygiene
406	Public health – Breast cancer screening
407	Public health – Cervical screening
408	Public health – Bowel cancer screening
409	Public health – Prevention of hazardous and harmful drug use
410	Public health – Public health research
488	Public health – Other public health
499	Public health – Not further defined
501	Health related care – Patient transport
502	Health related care – Patient transport subsidies
503	Health related care – Medications
504	Health related care – Aids and appliances
505	Health related care – Health administration
506	Health related care – Health research
588	Health related care – Other
599	Health related care – Not further defined
601	Other function – Home and Community Care
602	Other function – Aged care
603	Other function – Other welfare
688	Other function – Other
699	Other function – Not further defined

Collection and usage attributes

Guide for use:

CODE 101 Admitted patient care – Mental health program

An **admission** to a mental health program includes:

The component of the mental health program that provides admitted patient care. These services are delivered through specialised psychiatric hospitals and designated psychiatric units located within hospitals that are not specialised psychiatric hospitals.

NOTE: This is the admitted patient component of the mental health care program reported to the Mental Health Establishments NMDS.

Excludes residential care mental health programs, **ambulatory care** mental health programs which are provided as **outpatient** and **emergency department** care to non-admitted patients, and community-based (non-hospital) mental health programs.

CODE 102 Admitted patient care – Non-mental health program

An admitted patient non-mental health program includes:

All services, excluding mental health services, provided to admitted patients, including acute care, rehabilitative care, palliative care, geriatric evaluation and management, psychogeriatric care, maintenance care, newborn care and any

other admitted patient care e.g. organ procurement – posthumous. Also includes admitted patient services where service delivery is contracted to private hospitals or treatment facilities and **hospital in the home** services.

Excludes emergency department and outpatient care provided to non-admitted patients, and community-based (non hospital) care.

CODE 199 Admitted patient care – Not further defined

Comprises admitted patient care services that could be a combination of categories 101 and 102 but which could not be further disaggregated.

State and territory health authorities are only to report admitted patient care under codes 101 or 102.

CODE 201 Residential care – Mental health program

A residential mental health care program includes:

The component of the specialised mental health program that provides residential care. A **resident** in one **residential mental health service** cannot be concurrently a resident in another residential mental health service. A resident in a residential mental health service can be concurrently a patient admitted to a hospital.

Comprises the residential component of the mental health care program reported to the Mental Health Establishments NMDS.

Excludes residential aged care services, residential disability, alcohol and other drug treatment health care services and residential type care provided to admitted patients in hospitals. Also excludes mental health programs provided to admitted patients, emergency and outpatient care patients, and community health (non-hospital) and other ambulatory care patients.

CODE 202 Residential care – Non-mental health program

A residential non-mental health care program includes alcohol and other drug treatment health care services.

Excludes residential mental health care program services, residential aged care services, residential disability services and residential type care provided to admitted patients in hospitals. Also excludes services provided to admitted patients and patients receiving ambulatory care.

CODE 299 Residential care – Not further defined

Comprises residential care services that could be a combination of categories 201 and 202 but which could not be further disaggregated.

State and territory health authorities are only to report residential care under codes 201 or 202.

CODE 301 Ambulatory care – Mental health program

The component of a specialised mental health program supplied by a specialised mental health service that provides **ambulatory health care**.

Comprises the ambulatory component of the mental health care program reported to the Mental Health Establishments NMDS,

i.e. specialised mental health program services provided by emergency departments, outpatient clinics and community-based (non-hospital) services.

Excludes specialised mental health care provided to admitted and residential patients.

CODE 302 Ambulatory care – Emergency department

Comprises emergency department services provided in an **emergency department**.

Excludes specialised mental health services provided by emergency departments, outpatient clinics and community-based (non-hospital) services. Also excludes residential and admitted patient services.

CODE 303 Ambulatory care – General practitioner

This item is not currently required to be reported by state and territory health authorities.

The definition relates to the broad type of non-referred general practitioner services as specified on the Medicare Benefits Schedule website. These services comprise general practitioner attendances, including General Practitioner, Vocationally Registered General Practitioner (GP/VRGP) and other non-referred attendances, to non-admitted patients, and services provided by a practice nurse or registered Aboriginal Health Worker on behalf of a general practitioner.

This category is not limited to services funded by Medicare Australia. It also includes services funded from other sources such as Motor Vehicle Third Party Insurance and Workers Compensation Insurance, among others. Therefore, general or nurse practitioner services such as vaccinations for overseas travel are included regardless of their funding source. These non-referred general practitioner services are provided in private or group practices in medical clinics, community health care centres or hospital outpatient clinics.

Excludes mental health care services reported under code 301 and services provided to non-admitted patients in an emergency department.

CODE 304 Ambulatory care – Medical specialist

This item is not currently required to be reported by state and territory health authorities.

Specialist attendances, obstetrics, anaesthetics, radiotherapy, operations and assistance at operations care. These services are defined in the current Medicare Benefits Schedule. Includes services funded by Medicare Benefits Scheme, Motor Vehicle Third Party Insurance, Workers Compensation Insurance and from patient out-of-pocket payments. These services are provided in private or group practices in medical clinics, community health care centres or hospital outpatient clinics.

Includes salaried medical officers.

Excludes mental health care services reported under code 301 and services provided to non-admitted patients in an emergency department.

CODE 305 Ambulatory care – Imaging/pathology service.

This item is not currently required to be reported by state and territory health authorities.

Pathology and diagnostic imaging services as defined in the current Medicare Benefits Schedule. Includes services funded by Medicare Benefits Scheme, Motor Vehicle Third Party Insurance, Workers Compensation Insurance and from patient out-of-pocket payments. These services are provided in private or group practices in medical clinics, community health care centres or hospital outpatient clinics.

Excludes services provided to admitted or residential care patients and non-admitted patients in an emergency department.

CODE 306 Ambulatory care – Dental service

Includes any non-admitted patient and community dental services, including dental assessments, preventative services and treatments, regardless of funding source. Oral and maxillofacial services and cleft lip and palate services, as defined in the current Medicare Benefits Schedule, are also included in this category.

Includes dental services funded from a range of sources such as Medicare Benefits Scheme, Motor Vehicle Third Party Insurance and dental services funded by vouchers for dental care.

These dental services are provided in private or group practices in dental clinics, community health care centres or hospital outpatient clinics.

Excludes dental care provided to admitted patients in hospitals (same day or overnight) or to non-admitted patients in an emergency department.

CODE 307 Ambulatory care – Optometry service

This item is not currently required to be reported by state and territory health authorities.

Optometry services as defined in the current Medicare Benefits Schedule. Includes services funded by Medicare Benefits Scheme, Motor Vehicle Third Party Insurance, Workers Compensation Insurance and from patient out-of-pocket payments. These services are mainly provided in private or group practices, but may be provided in hospital outpatient centres.

Excludes optometry services provided to admitted or residential care patients or to non-admitted patients in an emergency department.

CODE 308 Ambulatory care – Allied health service

Includes services provided by the following allied health items. Aboriginal health worker, diabetes educator, audiologists, exercise physiologist, dietician, mental health worker, occupational therapist, physiotherapist, podiatrist or chiropodist, chiropractor, osteopath, psychologist and speech pathologist. These services are defined in the current Medicare Benefits Schedule. Includes services funded by Medicare Benefits Scheme, Motor Vehicle Third Party Insurance, Workers Compensation Insurance and from patient out-of-pocket payments.

Excludes allied health services provided to admitted or residential care patients or to non-admitted patients in an emergency department.

CODE 309 Ambulatory care – Community health services

Includes community health services such as family, maternal, child and youth health (including well baby clinics) as well as Aboriginal and Torres Strait Islander and migrant health services. Also includes health care for people with acute, post-acute, chronic and end of life illnesses, alcohol and drug treatment services, child psychology services, community midwifery, community nursing, school and district nursing, community rehabilitation, continence services, telehealth, dietetics, family planning and correctional health services.

Excludes mental health services reported under code 301 and services provided to admitted and residential care patients and non-admitted patients in an emergency department. Also excludes services already reported under codes 303 to 308.

CODE 388 Ambulatory care – Other

Comprises ambulatory care services other than those reported under codes 301 to 309.

CODE 399 Ambulatory care – Not further defined

Comprises ambulatory care services that could be a combination of categories 301 to 309 and 388, but which could not be further disaggregated, such as public outpatient services.

CODE 401 Public health – Communicable disease control

This category includes all activities associated with the development and implementation of programs to prevent the spread of communicable diseases.

Communicable disease control is recorded using three sub-categories:

HIV/AIDS, hepatitis C and sexually transmitted infections

Needle and syringe programs

Other communicable disease control.

The **public health** component of the HIV/AIDS, hepatitis C and STI strategies includes all activities associated with the development and implementation of prevention and education programs to prevent the spread of HIV/AIDS, hepatitis C and sexually transmitted infections.

CODE 402 Public health – Selected health promotion

This category includes those activities fostering healthy lifestyle and a healthy social environment overall, and health promotion activities targeted at health risk factors which lead to injuries, skin cancer and cardiovascular disease (for example diet, inactivity) that are delivered on a population-wide basis. The underlying criterion for the inclusion of health promotion programs within this category was that they are population health programs promoting health and wellbeing.

The Selected health promotion programs are:

Healthy settings (for example municipal health planning)

Public health nutrition

Exercise and physical activity

Personal hygiene

Mental health awareness promotion

Sun exposure and protection

Injury prevention including suicide prevention and female genital mutilation.

CODE 403 Public health – Organised immunisation

This category includes immunisation clinics, school immunisation programs, immunisation education, public awareness, immunisation databases and information systems.

Organised immunisation is recorded using three sub-categories:

Organised childhood immunisation (as defined by the National Health and Medical Research Council Schedule/Australian Standard Vaccination Schedule)

Organised pneumococcal and influenza immunisation—the target groups for pneumococcal immunisation are Indigenous people over 50 years and high-risk Indigenous younger people aged 15–49 years. Influenza vaccine is available free to all Australians 65 years of age and over, Indigenous people over 50 years and high-risk Indigenous younger people aged 15–19 years.

All other organised immunisation (for example tetanus)—as opposed to ad hoc or opportunistic immunisation.

CODE 404 Public health – Environmental health

This category relates to health protection education (for example safe chemical storage, water pollutants), expert advice on specific issues, development of standards, risk management and public health aspects of environmental health protection. The costs of monitoring and regulating are to be included where costs are borne by a regulatory agency and principally have a public health focus (for example radiation safety, and pharmaceutical regulation and safety).

CODE 405 Public health – Food standards and hygiene

This category includes the development, review and implementation of food standards, regulations and legislation as well as the testing of food by the regulatory agency.

CODE 406 Public health – Breast cancer screening

This category relates to Breast cancer screening and includes the complete breast cancer screening pathway through organised programs.

The breast cancer screening pathway includes such activities as recruitment, screen taking, screen reading, assessment (this includes fine needle biopsy), core biopsy, open biopsy, service management and program management.

CODE 407 Public health – Cervical screening

This category relates to organised cervical screening programs

such as the state cervical screening programs and rural access programs, including coordination, provision of screens and assessment services.

Cervical screening, funded through Medicare, for both screening and diagnostic services is also included. The methodology used in deriving the estimates is set out in the Jurisdictions' technical notes (section 11.2 of NPHER 2004-05).

CODE 408 Public health – Bowel screening

This category relates to organised bowel screening programs, such as the National Bowel Cancer Screening Program (NBCSP) and the Bowel Cancer Screening Pilot program. The screening pathway includes self administered home based tests by persons turning 55 years or 65 years of age across Australia who mail results in for analysis, the assessment/diagnostic service and program management.

CODE 409 Public health – Prevention of hazardous and harmful drug use

This category includes activities targeted at the general population with the aim of reducing the overuse or abuse of alcohol, tobacco, illicit and other drugs of dependence, and mixed drugs. The Australian Standard Classification of Drugs of Concern includes analgesics, sedatives and hypnotics, stimulants and hallucinogens, anabolic agents and selected hormones, antidepressants and anti-psychotics, and also miscellaneous drugs of concern.

Report for each sub-category as below, the aggregate of which will be total expenditure on Prevention of hazardous and harmful drug use:

Alcohol

Tobacco

Illicit and other drugs of dependence

Mixed.

CODE 410 Public health – Public health research

The basic criterion for distinguishing public health research and development from other public health activities is the presence in research and development of an appreciable element of novelty and resolution of scientific and/or technical uncertainty.

Includes mainly new or one-off research in the 8 core public health functions listed under codes 401 to 409.

General research and development work relating to the running of ongoing public health programs is included under the other relevant public health activities in codes 401 to 409.

CODE 488 Public health – Other public health

Comprises public health functions not reported to the National Public Health Expenditure Project.

CODE 499 Public health – Not further defined

Comprises public health services that could be a combination of categories 401 to 410 but which could not be further disaggregated.

State and territory health authorities are only to report public health services under codes 401 to 409.

CODE 501 Health related care – Patient transport

This item comprises transportation in a specially-equipped surface vehicle or in a designated air ambulance to and from facilities for the purposes of receiving medical and surgical care.

Includes all government ambulance services and transport provided by the Royal Flying Doctors Service, care flight and similar services, emergency transport services of public fire rescue departments or defence that operate on a regular basis for civilian emergency services (not only for catastrophe medicine).

Includes transport between hospitals or other medical facilities and transport to or from a hospital or other medical facility and a private residence or other non-hospital/medical services location.

The provider of this service could be a public or private hospital or an ambulance service.

CODE 502 Health related care – Patient transport subsidies

Government subsidies to private ambulance services e.g. patient transport vouchers, support programs to assist isolated patients with travel to obtain specialised health care.

It also includes transportation in conventional vehicles, such as taxi, when the latter is authorised and the costs are reimbursed to the patient (e.g. for patients undergoing renal dialysis or chemotherapy).

CODE 503 Health related care – Medications

This item is not currently required to be reported by state and territory health authorities.

Includes pharmaceuticals and other medical non-durables, prescribed medicines and over-the-counter pharmaceuticals. Included within these categories are: medicinal preparations, branded and generic medicines, drugs, patent medicines, serums and vaccines, vitamins and minerals and oral contraceptives, prescribed medicines exclusively sold to customers with a medical voucher, irrespective of whether it is covered by public or private funding. Includes branded and generic products, private households' non-prescription medicines and a wide range of medical non-durables such as bandages, condoms and other mechanical contraceptive devices, elastic stockings, incontinence articles and toothbrushes, toothpastes and therapeutic mouth washes.

CODE 504 Health related care – Aids and appliances

This item is not currently required to be reported by state and territory health authorities.

This item comprises glasses and other vision products, orthopaedic appliances & other prosthetics, hearing aids, medico-technical devices including wheelchairs and all other miscellaneous medical durables not elsewhere classified such as blood pressure instruments.

CODE 505 Health related care – Health administration

Administrative services which cannot be allocated to a specific health good and service. Those unallocatable services might include, for example, maintaining an office of the Chief Medical Officer; a Departmental liaison officer in the office of the Minister; or a number of other agency-wide items for which it is not possible to derive appropriate or meaningful allocations to particular health programs.

CODE 506 Health related care – Health research

Includes all research on health topics that is not included in public health research (code 410). That is, it includes all research classified under ABS Australian Standard Research Classification code 320000, excluding code 321200.

Excludes public health research and non-health related research.

CODE 588 Health related care – Other

Includes for example, services provided by health and health-related call centres and e-health information services.

Excludes health related care reported under codes 501 to 506 and health assessments provided under the Aged Care Assessment Program which are reported under code 602.

CODE 599 Health related care – Not further defined

Comprises health related care that could be a combination of categories 501 to 506 but which could not be further disaggregated.

State and territory health authorities are only to report health related care under codes 501 to 506.

CODE 601 Other function – Home and community care

This item is not currently required to be reported by state and territory health authorities.

Comprises Home and Community Care services reported under the HACC NMDS.

Information on these service categories is available in the following report:

National classifications of community services. Version 2.0. AIHW Cat. No. HWI 40. Canberra: Australian Institute of Health and Welfare, 2003.

Excludes services reported under codes 602 to 604.

CODE 602 Other function – Aged care

This item is not currently required to be reported by state and territory health authorities.

Includes residential care aged care programs, aged care assessment programs and other non-health aged care programs, such as respite care and day care activities.

Excludes services provided under the HACC program.

CODE 603 Other function – Other welfare

This item is not currently required to be reported by state and territory health authorities.

Includes services delivered to clients, or groups of clients with special needs such as the young or the disabled. Excludes aged care services reported under code 602.

CODE 688 Other function – Other

This item is not currently required to be reported by state and territory health authorities. Includes for example, car parking, accommodation for staff or for patients' relatives, or non-health related research.

CODE 699 Other function – Not further defined

This item is not currently required to be reported by state and territory health authorities.

Comprises other functions that could be a combination of categories 601 to 603 but which could not be further disaggregated.

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Reference documents:

Australian Bureau of Statistics 1998. Australian Standard Research Classification. Cat. no. 1297.0. Canberra: ABS.

Australian Government Department of Health and Ageing Medicare Benefits Schedule Book, 1 November 2006 available from http://www.health.gov.au/mbsonline

Australian Institute of Health and Welfare 2003. National classifications of community services. Version 2.0. AIHW cat. no. HWI 40. Canberra: AIHW.

Australian Institute of Health and Welfare 2007. National public health expenditure report 2004–05. Health and welfare series expenditure series no. 29. cat. no. HWE 36. Canberra: AIHW.

Data element attributes

Relational attributes

Implementation in Data Set Specifications:

Government health expenditure function revenue data cluster Health, Superseded 03/12/2008

Government health expenditure function revenue data element cluster Health, Standard 03/12/2008

Government health expenditure organisation expenditure capital consumption data element cluster Health, Superseded 01/04/2009

Government health expenditure organisation expenditure capital consumption data element cluster Health, Standard 01/04/2009

Government health expenditure organisation expenditure data cluster Health, Superseded 03/12/2008

Government health expenditure organisation expenditure data element cluster Health, Superseded 01/04/2009

Government health expenditure organisation expenditure data element cluster Health, Standard 01/04/2009

Government health expenditure organisation expenditure

employee related data element cluster Health, Superseded 01/04/2009

Government health expenditure organisation expenditure employee related data element cluster Health, Standard 01/04/2009

Government health expenditure organisation expenditure purchase of goods and services data element cluster Health, Superseded 01/04/2009

Government health expenditure organisation expenditure purchase of goods and services data element cluster Health, Standard 01/04/2009

Type of labour induction

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—labour induction type, code N
METeOR identifier:	270037
Registration status:	Health, Standard 01/03/2005
Definition:	Method used to induce labour, as represented by a code.
Data Element Concept:	Birth event—labour induction type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
0	None
1	Oxytocin
2	Prostaglandins
3	Artificial rupture of membranes (ARM)
4	Other

Data element attributes

Collection and usage attributes

Guide for use:	More than one method of induction can be recorded, except where 0=none applies.
Comments:	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.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Type of labour induction, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)

Type of usual accommodation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—accommodation type (prior to admission), code N
METeOR identifier:	270079
Registration status:	Health, Standard 01/03/2005
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.
Data Element Concept:	Person—accommodation type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
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 and usage attributes

Collection methods:	The above classifications have been based on Question 16 of Form NH5. The Australian Government Department of Health and Aged Care has introduced a new Aged Care Application and Approval form which replaces the NH5.

Data element attributes

Collection and usage attributes

Collection methods:	This metadata item is not available for New South Wales State nursing homes. As this 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 metadata item (see metadata item Admission mode).

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Type of usual accommodation, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)

Implementation in Data Set Specifications:

Admitted patient mental health care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Type of visit to emergency department

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—type of visit to emergency department, code N
METeOR identifier:	270362
Registration status:	Health, Standard 01/03/2005
Definition:	The reason the patient presents to an emergency department, as represented by a code.
Data Element Concept:	Non-admitted patient emergency department service episode—type of visit to emergency department

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
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.

Data element attributes

Collection and usage attributes

Comments:	Required for analysis of emergency department services.

Source and reference attributes

Submitting organisation:	National Institution Based Ambulatory Model Reference Group
Origin:	National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Type of visit to emergency department, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.6 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Non-admitted patient emergency department care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Underlying cause of death

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—underlying cause of death, code (ICD-10 2nd edn) ANN-ANN
Synonymous names:	UCOD code
METeOR identifier:	307931
Registration status:	Health, Standard 01/10/2008
Definition:	The disease or injury which initiated the train of morbid events leading directly to a person's death or the circumstances of the accident or violence which produced the fatal injury, as represented by a code. (WHO 2004)
Data Element Concept:	Person—underlying cause of death

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, (2nd edition)
Representation class:	Code
Data type:	String
Format:	ANN-ANN
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:	Underlying cause of death is central to mortality coding and comparable international mortality reporting.
Comments:	The Australian Bureau of Statistics (ABS) codes and classifies the underlying cause of death (UCOD) according to the rules and guidelines for mortality coding adopted by the World Health Assembly and set out in the World Health Organisation's International Classification of Diseases and Related Health Problems (ICD). The ABS uses the Mortality Medical Data System (MMDS) to process and code cause-of-death information reported on death certificates.

Source and reference attributes

Submitting organisation:	Australian Bureau of Statistics
Origin:	Australian Bureau of Statistics 2004. Information Paper: Cause of death certification. Catalogue no. 1205.0.55.001. Canberra: Australian Bureau of Statistics. Viewed 31 August 2005. National Center for Health Statistics 2005. About the Mortality

Medical Data System. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Viewed 31 August 2005.

World Health Organisation 2004. The International statistical classification of diseases and related health problems, tenth revision, (2nd edn). Geneva: World Health Organisation.

Reference documents:

Australian Bureau of Statistics 2004. Information Paper: Cause of death certification. Catalogue no. 1205.0.55.001. Canberra: Australian Bureau of Statistics. Viewed 31 August 2005.

World Health Organisation 2004. The International statistical classification of diseases and related health problems, tenth revision, (2nd edn). Geneva: World Health Organisation.

Relational attributes

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Conditional obligation:
If a date of death is recorded, the cause of death must also be recorded. These data are recorded regardless of the cause of death.

Urgency of admission

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—admission urgency status, code N
METeOR identifier:	269986
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the **admission** has an urgency status assigned and, if so, whether **admission** occurred on an emergency basis, as represented by a code.
Data Element Concept:	Episode of admitted patient care—admission urgency status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Urgency status assigned - emergency
2	Urgency status assigned - elective
3	Urgency status not assigned

Supplementary values:

9	Not known/not reported

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Urgency status assigned - emergency

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
- 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.

CODE 2 Urgency status assigned - Elective

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 code 1 in metadata item Reason for removal from an elective surgery waiting list code N) will be assigned an Admission urgency status code N code of 2. 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 code 2 in metadata item Reason for removal from an elective surgery waiting list code N), will be assigned an Admission urgency status code N code of 1.

CODE 3 Urgency status not assigned

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
- planned readmissions for the patient to receive limited care or treatment for a current condition, for example dialysis or chemotherapy.

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.

CODE 9 Not known/not reported

This code is 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.

Source and reference attributes

Submitting organisation: Emergency definition working party

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Urgency of admission, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.4 KB)

Implementation in Data Set Specifications:

Admitted patient care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Vascular history

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—vascular condition status (history), code NN
METeOR identifier:	269958
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the person has had a history of vascular conditions, as represented by a code.
Context:	The vascular history of the patient is important as an element in defining future risk for a cardiovascular event and as a factor in determining best practice management for various cardiovascular risk factor(s). It may be used to map vascular conditions, assist in risk stratification and link to best practice management.
Data Element Concept:	Person—vascular condition status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Myocardial infarction
02	Unstable angina pectoris
03	Angina
04	Heart failure
05	Atrial fibrillation
06	Other dysrhythmia or conductive disorder
07	Rheumatic heart disease
08	Non-rheumatic valvular heart disease
09	Left ventricular hypertrophy
10	Stroke
11	Transient ischaemic attack
12	Hypertension
13	Peripheral vascular disease (includes abdominal aortic aneurism)
14	Deep vein thrombosis
15	Other atherosclerotic disease
16	Carotid stenosis

	17	Vascular renal disease
	18	Vascular retinopathy (hypertensive)
	19	Vascular retinopathy (diabetic)
	97	Other vascular
	98	No vascular history
Supplementary values:	99	Unknown/not stated /not specified

Collection and usage attributes

Comments: Can be mapped to the current version of ICD-10-AM.

Source and reference attributes

Origin: International Classification of Diseases - Tenth Revision - Australian Modification (3rd Edition 2000), National Centre for Classification in Health, Sydney

Data element attributes

Collection and usage attributes

Guide for use: More than one code can be recorded.

Collection methods: Ideally, vascular history information is derived from and substantiated by clinical documentation.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Origin: National Centre for Classification in Health

National Data Standards for Injury Surveillance Advisory Group

Relational attributes

Related metadata references: Supersedes Vascular history, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.8 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Vascular procedures

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—vascular procedures (history), code NN
METeOR identifier:	269962
Registration status:	Health, Standard 01/03/2005
Definition:	The vascular procedures the person has undergone, as represented by a code.
Data Element Concept:	Person—vascular procedure

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Amputation for arterial vascular insufficiency
02	Carotid endarterectomy
03	Carotid angioplasty/stenting
04	Coronary angioplasty/stenting
05	Coronary artery bypass grafting
06	Renal artery angioplasty/stenting
07	Heart transplant
08	Heart valve surgery
09	Abdominal aortic aneurism repair/bypass graft/stenting
10	Cerebral circulation angioplasty/stenting
11	Femoral/popliteal bypass/graft/stenting
12	Congenital heart and blood vessel defect surgery
13	Permanent pacemaker implantation
14	Implantable cardiac defibrillator
98	Other

Supplementary values:

99	Unknown/not recorded

Data element attributes

Collection and usage attributes

Collection methods:	Ideally, Vascular procedure information is derived from and substantiated by clinical documentation.

Comments: In settings where the monitoring of a person's health is ongoing and where a history can change over time (such as general practice), the Service contact—service contact date, DDMMYYYY should be recorded.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Origin: Australian Institute of Health and Welfare (AIHW) 2001. Heart, stroke and vascular diseases - Australian facts 2001. AIHW Cat. No. CVD 13. Canberra: AIHW, National Heart foundation of Australia, National Stroke Foundation of Australia (CVD Series No. 14)

Relational attributes

Related metadata references: Supersedes Vascular procedures, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB)

Implementation in Data Set Specifications: Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Ventricular ejection fraction measurement indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—ventricular ejection fraction test performed indicator, yes/no code N
Synonymous names:	EF measurement indicator
METeOR identifier:	347672
Registration status:	Health, Standard 01/10/2008
Definition:	An indicator of whether a person's ventricular ejection fraction was measured, as represented by a code.
Data Element Concept:	Person—ventricular ejection fraction test performed indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 9 Not stated/inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:

Code 1 Yes

Record if a test was performed to measure the person's ventricular ejection fraction.

Code 2 No

Record if no test was performed to measure the person's ventricular ejection fraction.

Relational attributes

Related metadata references:	See also Ventricular ejection fraction test—test type, code N Health, Standard 01/10/2008
Implementation in Data Set Specifications:	Ventricular ejection fraction cluster Health, Standard 01/10/2008

Ventricular ejection fraction test result (percentage)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Ventricular ejection fraction—test result, percentage N[N].N
Synonymous names:	EF result (percentage)
METeOR identifier:	347002
Registration status:	Health, Standard 01/10/2008
Definition:	A person's ventricular ejection fraction result expressed as a percentage.
Data Element Concept:	Ventricular ejection fraction—test result

Value domain attributes

Representational attributes

Representation class:	Percentage
Data type:	Number
Format:	N[N].N
Maximum character length:	3

Supplementary values:

Value	Meaning
99.9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	The person's ejection fraction result recorded should be between 0 and 80%.
Comments:	The patient is not alive or is in Pulseless Electrical Activity (PEA) if the result is 0%.

Relational attributes

Related metadata references:	See also Ventricular ejection fraction—test result, code N Health, Standard 01/10/2008
Implementation in Data Set Specifications:	Ventricular ejection fraction cluster Health, Standard 01/10/2008 *Conditional obligation:* To be provided when the ventricular ejection fraction is measured.

Ventricular ejection fraction test result (code)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Ventricular ejection fraction—test result, code N
Synonymous names:	EF result (code)
METeOR identifier:	346993
Registration status:	Health, Standard 01/10/2008
Definition:	The person's ventricular ejection fraction result, as represented by a code.
Data Element Concept:	Ventricular ejection fraction—test result

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Normal
2	Mild
3	Moderate
4	Severe

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Normal

Use this code when the ejection fraction is greater than 50%

CODE 2 Mild

Use this code when the ejection fraction is greater than or equal to 45% but less than or equal to 50%

CODE 3 Moderate

Use this code when the ejection fraction is greater than or equal to 35% but less than 45%

CODE 4 Severe

Use this code when the ejection fraction is less than 35%

CODE 9 Not stated/inadequately described

Not for use in primary data collections.

Data element attributes

Relational attributes

Related metadata references:

See also Ventricular ejection fraction—test result, percentage N[N].N Health, Standard 01/10/2008

Implementation in Data Set Specifications:

Ventricular ejection fraction cluster Health, Standard 01/10/2008

Conditional obligation:
To be provided when the ventricular ejection fraction is measured.

Ventricular ejection fraction test type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Ventricular ejection fraction test—test type, code N
Synonymous names:	EF measurement test
METeOR identifier:	344253
Registration status:	Health, Standard 01/10/2008
Definition:	The type of test used to measure a person's ventricular ejection fraction, as represented by a code.
Data Element Concept:	Ventricular ejection fraction test—test type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Echocardiography
2	Angiography
3	Gated blood pool scan
4	Magnetic resonance imaging (MRI)

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Relational attributes

Related metadata references:	See also Person—ventricular ejection fraction test performed indicator, yes/no code N Health, Standard 01/10/2008
Implementation in Data Set Specifications:	Ventricular ejection fraction cluster Health, Standard 01/10/2008

Conditional obligation:
To be provided when the ventricular ejection fraction is measured.

Visa type—health professional

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—visa type, code AANNN
METeOR identifier:	381681
Registration status:	Health, Standard 10/12/2009
Definition:	The category of visa (or travel authority) granted by Australia for foreign nationals (excluding New Zealand citizens) who are registered as health professionals in Australia, to travel to, enter and remain in Australia, as represented by a code.
Data Element Concept:	Registered health professional—visa type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	AANNN
Maximum character length:	5

Collection and usage attributes

Guide for use:	Includes all 2-digit alphabetical classes and 3-digit numeric sub-classes as described in the Migration Regulations 1994 of the Migration Act 1958.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Further information regarding visas can be obtained from the Australian Department of Immigration and Citizenship or visit their website www.immi.gov.au
Reference documents:	The Migration Regulations 1994 of the Migration Act 1958.

Data element attributes

Collection and usage attributes

Guide for use:	A **visa** (or travel authority) is permission or authority granted by Australia for foreign nationals to travel to, enter and remain in Australia. Immigration law requires all travellers who are not Australian citizens to obtain authority, in the form of a visa or travel authority, to travel to, and stay in Australia. A **temporary visa** is the permission or authority granted by the Australian government for foreign nationals to travel to and enter Australia, and stay up to a specified period of time. A **permanent visa** is the permission or authority granted by the Australian government for foreign nationals to live in Australia permanently.

All applicants must meet the English language requirements based on their nominated occupation.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Further information regarding visas can be obtained from the Australian Department of Immigration and Citizenship or visit their website www.immi.gov.au

Reference documents: Registered Health labour force NMDS 2010-2011

Relational attributes

Implementation in Data Set Specifications:

Registered chiropractic labour force DSS Health, Standard 10/12/2009

Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009

Registered medical professional labour force DSS Health, Standard 10/12/2009

Registered midwifery labour force DSS Health, Standard 10/12/2009

Registered nursing professional labour force DSS Health, Standard 10/12/2009

Registered optometry labour force DSS Health, Standard 10/12/2009

Registered osteopathy labour force DSS Health, Standard 10/12/2009

Registered pharmacy labour force DSS Health, Standard 10/12/2009

Registered physiotherapy labour force DSS Health, Standard 10/12/2009

Registered podiatry labour force DSS Health, Standard 10/12/2009

Registered psychology labour force DSS Health, Standard 10/12/2009

Visual acuity (left eye)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—visual acuity (left eye), code NN
METeOR identifier:	269963
Registration status:	Health, Standard 01/03/2005
Definition:	A person's left eye visual acuity, as represented by a code.
Data Element Concept:	Person—visual acuity

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	6/5
02	6/6
03	6/9
04	6/12
05	6/18
06	6/24
07	6/36
08	6/60
09	CF (count fingers)
10	HM (hand movement)
11	PL (perceive light)
12	BL (blind)
13	6/7.5

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

Record actual result for both right and left eyes:

- 1st field: Right eye
- 2nd field: Left eye.

Test wearing distance glasses if prescribed.

Use pinhole if vision less than 6/6.

Collection methods:

One of the most often utilised tests for visual acuity uses the Snellen chart.

- At a distance of 6 metres all subjects should be able to read the 6/6 line with each eye using the proper refractive correction.
- Both eyes are to be opened and then cover one eye with the ocular occluder.
- The observer has to read out the smallest line of letters that he/she can see from the chart.
- This is to be repeated with the other eye.

Eye examination should be performed by an ophthalmologist or a suitably trained clinician:

- within five years of **diagnosis** and then every 1-2 years for patients whose diabetes onset was at age under 30 years
- at diagnosis and then every 1-2 years for patients whose diabetes onset was at age 30 years or more.

Source and reference attributes

Origin:

National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Reference documents:

Vision Australia, No 2, 1997/8; University of Melbourne

World Health Organization

US National Library of Medicine

Diabetes Control and Complications Trial: DCCT New England Journal of Medicine, 329(14), September 30, 1993

Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus

Relational attributes

Related metadata references:

Supersedes Visual acuity, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.3 KB)

See also Person—visual acuity (right eye), code NN Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Visual acuity (right eye)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—visual acuity (right eye), code NN
METeOR identifier:	270381
Registration status:	Health, Standard 01/03/2005
Definition:	A person's right eye visual acuity, as represented by a code.
Data Element Concept:	Person—visual acuity

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	6/5
02	6/6
03	6/9
04	6/12
05	6/18
06	6/24
07	6/36
08	6/60
09	CF (count fingers)
10	HM (hand movement)
11	PL (perceive light)
12	BL (blind)
13	6/7.5

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

Record actual result for both right and left eyes:

- 1st field: Right eye
- 2nd field: Left eye.

Test wearing distance glasses if prescribed.

Use pinhole if vision less than 6/6.

Collection methods:

One of the most often utilised tests for visual acuity uses the Snellen chart.

- At a distance of 6 metres all subjects should be able to read the 6/6 line with each eye using the proper refractive correction.
- Both eyes are to be opened and then cover one eye with the ocular occluder.
- The observer has to read out the smallest line of letters that he/she can see from the chart.
- This is to be repeated with the other eye.

Eye examination should be performed by an ophthalmologist or a suitably trained clinician:

- within five years of **diagnosis** and then every 1-2 years for patients whose diabetes onset was at age under 30 years
- at diagnosis and then every 1-2 years for patients whose diabetes onset was at age 30 years or more.

Source and reference attributes

Origin:

National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Reference documents:

Vision Australia, No 2, 1997/8; University of Melbourne

World Health Organization

US National Library of Medicine

Diabetes Control and Complications Trial: DCCT New England Journal of Medicine, 329(14), September 30, 1993

Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus

Relational attributes

Related metadata references:

See also Person—visual acuity (left eye), code NN Health, Standard 01/03/2005

Supersedes Visual acuity, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.3 KB)

Implementation in Data Set Specifications:

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Waist circumference (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—waist circumference (measured), total centimetres NN[N].N
METeOR identifier:	270129
Registration status:	Health, Standard 01/03/2005
Definition:	A person's waist circumference measured in centimetres.
Data Element Concept:	Person—waist circumference

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NN[N].N
Maximum character length:	4

Supplementary values:

Value	Meaning
999.9	Not measured

Unit of measure: Centimetre (cm)

Data element attributes

Collection and usage attributes

Collection methods:

The collection of anthropometric measurements, particularly in those who are overweight or obese or who are concerned about their weight, should be performed with great sensitivity, and without drawing attention to an individual's weight.

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

In order to ensure consistency in measurement, the following measurement protocol should be used.

Measurement protocol:

The measurement of waist 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 waist 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 waist 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.

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, 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 waist 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 & 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.

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 waist 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.

Comments:

This metadata item 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 metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

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. However 5-year age groups are not generally suitable for children and adolescents. 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 waist circumference in categories. It is recommended that 5-cm groupings are used for this purpose. Waist circumference should not be rounded before categorisation. The following categories may be appropriate for describing the waist circumferences of Australian men, women children and adolescents, although the range will depend on the population.

Waist

35 cm = Waist

40 cm = Waist

... in 5 cm categories

105 cm = Waist

Waist => 110 cm

Source and reference attributes

Submitting organisation:

World Health Organization International Society for the Advancement of Kinanthropometry

Relational attributes

Related metadata references:

Supersedes Waist circumference - measured, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (26.0 KB)

Is used in the formation of Adult—waist-to-hip ratio, N.NN Health, Standard 01/03/2005

Implementation in Data Set Specifications:	Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006
	Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007
	Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009
	Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Waist circumference risk indicator—adults

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Adult—waist circumference risk indicator, Caucasian adult code N
METeOR identifier:	270205
Registration status:	Health, Standard 01/03/2005
Definition:	The sex specific category of risk of metabolic complications associated with excess abdominal adiposity in adult Caucasians, as represented by a code.
Data Element Concept:	Adult—waist circumference risk indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Not at risk (male waist circumference less than 94 cm, female waist circumference less than 80 cm)
	2	Increased (male waist circumference ≥ 94 cm, female waist circumference ≥ 80 cm)
	3	Substantially increased (male waist circumference ≥ 102 cm, female waist circumference ≥ 88 cm)
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item cannot be determined if waist circumference measured has not been collected (i.e. is coded to 999.9) and/or sex is not stated (i.e. coded to 9). This metadata item applies to persons aged 18 years or older.
Collection methods:	This metadata item should be derived after the data entry of waist circumference measured. It should be stored on the raw data set as a continuous variable and should not be aggregated or rounded.
Comments:	This metadata item is recommended for use in population surveys and health care settings. Recent evidence suggests that waist circumference may provide a more practical correlate of abdominal fat distribution and associated ill health.

The identification of risk using waist circumference is population-specific and will depend on levels of obesity and other risk factors for cardiovascular disease and non-insulin dependent diabetes mellitus.

Populations differ in the level of risk associated with a particular waist circumference, so that globally applicable cut-off points cannot be developed. For example, complications associated with abdominal fat in black women and those of South Asian descent are markedly higher for a given level of BMI than in Europeans. Also, although women have almost the same absolute risk of coronary heart disease as men at the same WHR, they show increases in relative risk of coronary heart disease at lower waist circumferences than men. Thus, there is a need to develop sex-specific waist circumference cut-off points appropriate for different populations. Hence, the cut-off points used for this metadata item are associated with obesity in Caucasians. This issue is being investigated further.

Cut-off points for children and adolescents are also being developed. Research shows that a high childhood BMI and high trunk skin fold values are predictive of abdominal obesity as an adult and waist circumference measures in childhood track well into adulthood.

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 metadata item currently exist for sex, date of birth, country of birth and Indigenous status and smoking. Metadata items are being developed for physical activity.

Source and reference attributes

Origin: World Health Organization

Reference documents: Obesity: Preventing and Managing the Global Epidemic: Report of a World Health Organization (WHO) Expert Committee. Geneva: WHO, 2000 as described by Han TS et al (1995)

Relational attributes

Related metadata references: Supersedes Waist circumference risk indicator - adults, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (20.5 KB)

Waist-to-hip ratio

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Adult—waist-to-hip ratio, N.NN
METeOR identifier:	270207
Registration status:	Health, Standard 01/03/2005
Definition:	A ratio calculated by dividing the waist circumference of an adult person by the hip circumference of that same person.
Data Element Concept:	Adult—waist-to-hip ratio

Value domain attributes

Representational attributes

Representation class:	Ratio
Data type:	Number
Format:	N.NN
Maximum character length:	3

Data element attributes

Collection and usage attributes

Guide for use:	Formula: WHR = waist circumference (cm) divided by hip circumference (cm). Adult WHR is a continuous variable. Adult WHR 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:	As there are no cut-off points for waist to hip ratio for children and adolescents, it is not necessary to calculate this item for those aged under 18 years. Waist-to-hip ratio (WHR) should be derived after the data entry of waist circumference and hip circumference. It should be stored on the raw data set as a continuous variable and should not be aggregated or rounded.
Comments:	Adult cut-off points for WHR, 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. This metadata item applies to persons aged 18 years or older as

no cut off points have been developed for children and adolescents. It is recommended for use in population surveys and health care settings.

More recently it has emerged that waist circumference alone, or in combination with other metabolic measures, is a better indicator of risk and reduces the errors in WHR measurements. WHR is therefore no longer a commonly used measure.

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.

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.

Waist- to-hip ratio (WHR) 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 public health policy
- to ascertain determinants and consequences of abdominal obesity - in nutrition and physical activity surveillance and long-term planning.

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.

Source and reference attributes

Origin:

National Health Data Committee

National Centre for Monitoring Cardiovascular Disease

Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

Supersedes Waist-to-hip ratio, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.0 KB)

Is formed using Person—waist circumference (measured), total centimetres NN[N].N Health, Standard 01/03/2005

Is formed using Person—hip circumference (measured), total centimetres NN[N].N Health, Standard 01/03/2005

Waiting list category

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective care waiting list episode—elective care type, code N
METeOR identifier:	335048
Registration status:	Health, Standard 07/12/2005
Definition:	The type of elective hospital care that a patient requires, as represented by a code.
Data Element Concept:	Elective care waiting list episode—elective care type

Value domain attributes

Representational attributes

Classification scheme:	Australian Classification of Health Interventions (ACHI) 5th edition
Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Elective surgery
2	Other

Collection and usage attributes

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.

CODE 1 Elective surgery

All elective surgery, that is excluding procedures listed in exclusion list for Code 2, should be included in this code.

CODE 2 Other

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
- 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 Australian Classification of Health Interventions (ACHI) 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.

Comments:

The table of Australian Classification of Health Interventions (ACHI) (5th edition) 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 to facilitate more readily the identification of the exclusions when the list of codes is not used.

ACHI CODES FOR THE EXCLUDED PROCEDURES:

Organ or tissue transplant:
90172-00 [555] 90172-01 [555] 90204-00 [659] 90204-01 [659] 90205-00 [660] 90205-01 [660] 13700-00 [801] 13706-08 [802] 13706-00 [802] 13706-06 [802] 13706-07 [802] 13706-09 [802] 13706-10 [802]

30375-21 [817] 90317-00 [954] 90324-00 [981] 36503-00 [1058] 36503-01 [1058] 14203-01 [1906]

Procedures associated with obstetrics: 16511-00 [1274] Obstetric Blocks [1330] to [1345] and [1347] 90463-01 [1330] 90488-00 [1330]

Biopsy (needle) of:
- kidney: 36561-00 [1047]
- 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] 41898-00 [543] 41898-01 [544] 41889-01 [543] 41849-00 [520] 41764-03 [520] 41855-00 [520]

Peritoneal renal dialysis:
13100-06 [1061] 13100-07 [1061] 13100-08 [1061] 13100-00 [1060]

Endoscopy of biliary tract:
30484-00 [957] 30484-01 [957] 30484-02 [974] 30494-00 [971] 30452-00 [971] 30491-00 [958] 30491-01 [958] 30485-00 [963] 30485-01 [963] 30452-01 [958] 30450-00 [959] 30452-02 [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]

Panendoscopy:
30476-03 [874] 32095-00 [891] 30568-00 [893] 30569-00 [894] 30473-05 [1005] 30473-00 [1005] 30473-02 [1005] 30478-00 [1006] 30478-14 [1006] 30478-01 [1007] 30478-02 [1007] 30478-03 [1007] 30478-15 [1007] 30478-16 [1007] 30478-17 [1007] 30478-20 [1007] 30478-21 [1007] 30473-01 [1008] 30478-04 [1008] 30473-06 [1008] 30478-18 [1008]

Endoscopy of large intestine, rectum and anus:
32075-00 [904] 32090-00 [905] 32084-00 [905] 30479-02 [908] 90308-00 [908] 32075-01 [910] 32078-00 [910] 32081-00 [910] 32090-01 [911] 32093-00 [911] 32084-01 [911] 32087-00 [911] 30479-01 [931] 90315-00 [933]

Miscellaneous cardiac:
38603-00 [642] 38600-00 [642] 38256-00 [647] 38256-01 [647] 38256-02 [647] 38278-00 [648] 38278-01 [648] 38284-00 [648] 90202-00 [649] 38470-00 [649] 38473-00 [649] 38281-01 [650] 38281-02 [650] 38281-03 [650] 38281-04 [650] 38281-05 [650] 38281-06 [650] 38281-07 [651] 38281-07 [651] 38281-08 [651] 38281-09 [651] 38281-10 [651] 38281-00 [652] 38278-02 [654] 38456-07 [654] 90203-00 [654] 38284-01 [654] 90219-00 [663] 38281-11 [655] 38281-12 [655] 38212-00 [665] 38209-00 [665] 38200-00 [667] 38203-00 [667] 38206-00 [667] 35324-00 [740] 35315-00 [758] 35315-01 [758] 90214-00 [648] 90202-01 [649]
38281-13 [652] 38278-03 [654] 38284-02 [654] 90214-01 [654] 90214-02 [654] 90203-01 [654] 38456-08 [654] 38281-14 [655] 38212-01 [665] 38213-00 [665]

Endovascular interventional:
35304-01 [670] 35305-00 [670] 35304-00 [670] 35305-01 [670] 35310-00 [671] 35310-01 [671] 35310-03 [671] 35310-04 [671] 35310-02 [671] 35310-05 [671] 34524-00 [694] 13303-00 [694] 34521-01 [694] 32500-01 [722] 32500-00 [722] 13300-01 [738] 13300-02 [738] 13319-00 [738] 13300-00 [738] 13815-00 [738] 13815-01 [738] 34521-02 [738] 34530-04 [738] 90220-00 [738]

Urethroscopy:
36800-00 [1090] 36800-01 [1090] 37011-00 [1093] 37008-01 [1093] 37008-00 [1093] 37315-00 [1112] 37318-01 [1116] 36815-01 [1116] 37854-00 [1116] 35527-00 [1116] 37318-04 [1117] 36800-03 [1090] 37318-02 [1116] 37318-03 [1116]

Dental:
Blocks [450] to [490]
97022-00 [451] 97025-00 [451] 97113-00 [453] 97121-01 [454] 97123-01 [454] 97165-01 [455] 97221-00 [456] 97222-00 [456] 97231-00 [456] 97232-00 [456] 97233-00 [456] 97234-00 [456] 97384-00 [461] 97386-01 [461] 97415-00 [462] 97417-00 [462] 97431-00 [463] 97433-00 [463] 97434-00 [463] 97437-00 [463] 97445-00 [464] 97455-00 [464] 97511-01 [465] 97512-01 [465] 97513-01 [465] 97514-02 [465] 97515-02 [465] 97541-01 [465] 97542-01 [465] 97543-01 [465] 97544-00 [465] 97545-00 [465] 97521-01 [466] 97522-01 [466] 97523-01 [466] 97524-00 [466] 97525-00 [466] 97531-00 [466] 97532-00 [466] 97533-00 [466] 97534-00 [466] 97535-00 [466] 97551-01 [466] 97552-01 [466] 97553-01 [466] 97554-01 [466] 97555-01 [466] 97572-01 [469] 97574-01 [469] 97575-00 [469] 97578-00 [469] 97582-01 [469] 97583-01 [469] 97631-00 [470] 97632-00 [471] 97649-00 [471] 97671-00 [473] 97672-00 [473] 97673-00 [473] 97732-00 [474] 97733-00 [474] 97739-00 [474] 97741-00 [475] 97762-00 [476] 97765-00 [476] 97768-00 [476] 97825-00 [479]

Other diagnostic and non-surgical:
90347-01 [983] 30406-00 [983] 90347-02 [983] 30408-00 [983]

Blocks [1820] to [1939], [1940] to [2016]

11003-00 [1825] 11018-00 [1826] 11018-01 [1826] 11614-00 [1851] 11602-00 [1852] 11604-00 [1852] 11605-00 [1852] 11610-00 [1852] 11611-00 [1852] 11612-00 [1852] 11709-00 [1853] 11917-00 [1860] 11919-00 [1860] 96207-00 [1921] 96207-01 [1921] 96207-02 [1921] 96207-03 [1921] 96207-04 [1921] 96207-05 [1921] 96207-06 [1921] 96207-07 [1921] 96207-08 [1921] 96207-09 [1921] 96208-00 [1921] 96208-01 [1921] 96208-02 [1921] 96208-03 [1921] 96208-04 [1921] 96208-05 [1921] 96208-06 [1921] 96208-07 [1921] 96208-08 [1921] 96208-09 [1921] 55084-00 [1943] 55600-00 [1943] 60000-01 [1992] 60048-00 [1996] 60060-00 [1997] 60060-01 [1997] 61442-00 [2012] 96196-00 [1920] 96196-01 [1920] 96196-02 [1920] 96196-03 [1920] 96196-04 [1920] 96196-05 [1920] 96196-06 [1920] 96196-07 [1920] 96196-08 [1920] 96196-09 [1920] 96197-00 [1920] 96197-01 [1920] 96197-02 [1920] 96197-03 [1920] 96197-04 [1920] 96197-05 [1920] 96197-06 [1920] 96197-07 [1920] 96197-08 [1920] 96197-09 [1920] 96198-00 [1920] 96198-01 [1920] 96198-02 [1920] 96198-03 [1920] 96198-04 [1920] 96198-05 [1920] 96198-06 [1920] 96198-07 [1920] 96198-08 [1920] 96198-09 [1920] 96199-00 [1920] 96199-01 [1920]

96199-02 [1920] 96199-03 [1920] 96199-04 [1920] 96199-05 [1920] 96199-06 [1920] 96199-07 [1920] 96199-08 [1920] 96199-09 [1920] 96200-00 [1920] 96200-01 [1920] 96200-02 [1920] 96200-03 [1920] 96200-04 [1920] 96200-05 [1920] 96200-06 [1920] 96200-07 [1920] 96200-08 [1920] 96200-09 [1920] 96201-00 [1920] 96201-01 [1920] 96201-02 [1920] 96201-03 [1920] 96201-04 [1920] 96201-05 [1920] 96201-06 [1920] 96201-07 [1920] 96201-08 [1920] 96201-09 [1920] 96202-00 [1920] 96202-01 [1920] 96202-02 [1920] 96202-03 [1920] 96202-04 [1920] 96202-05 [1920] 96202-06 [1920] 96202-07 [1920] 96202-08 [1920] 96202-09 [1920] 96203-00 [1920] 96203-01 [1920] 96203-02 [1920] 96203-03 [1920] 96203-04 [1920] 96203-05 [1920] 96203-06 [1920] 96203-07 [1920] 96203-08 [1920] 96203-09 [1920] 96204-00 [1920] 96204-01 [1920] 96204-02 [1920] 96204-03 [1920] 96204-04 [1920] 96204-05 [1920] 96204-06 [1920] 96204-07 [1920] 96204-08 [1920] 96204-09 [1920] 96205-00 [1920] 96205-01 [1920] 96205-02 [1920] 96205-03 [1920] 96205-04 [1920] 96205-05 [1920] 96205-06 [1920] 96205-07 [1920] 96205-08 [1920] 96205-09 [1920] 96206-00 [1920] 96206-01 [1920] 96206-02 [1920] 96206-03 [1920] 96206-04 [1920] 96206-05 [1920] 96206-06 [1920] 96206-07 [1920] 96206-08 [1920] 96206-09 [1920]

Source and reference attributes

Reference documents: National Centre for Classification in Health (NCCH) 2006. The Australian Classification of Health Interventions (ACHI) – Fifth Edition - Tabular list of interventions and Alphabetic index of interventions. Sydney: NCCH, Faculty of Health Sciences, The University of Sydney.

Data element attributes

Source and reference attributes

Submitting organisation: Hospital Access Program Waiting Lists Working Group

Waiting Times Working Group

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Elective care waiting list episode—elective care type, code N Health, Superseded 07/12/2005

Waiting time at a census date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—waiting time (at a census date), total days N[NNN]
METeOR identifier:	269961
Registration status:	Health, Standard 01/03/2005
Definition:	The time elapsed (in days) for a patient on the elective surgery waiting list from the date they were added to the waiting list to a designated census date.
Context:	Elective surgery
Data Element Concept:	Elective surgery waiting list episode—waiting time

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:

The number of days is calculated by subtracting the Elective care waiting list episode—listing date for care, DDMMYYYY from the Hospital census (of elective surgery waitlist patients)—census date, DDMMYYYY, 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 Elective surgery waiting list episode—clinical urgency, code N 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 Elective care waiting list episode—listing date for care, DDMMYYYY from the Elective care waiting list episode—category reassignment date, DDMMYYYY. 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 Elective care waiting list episode—category reassignment date, DDMMYYYY from the subsequent Elective care waiting list episode—category reassignment date, DDMMYYYY, and then adding the days 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.

Comments:

Elective surgery waiting times data collections include measures of waiting times at removal and at designated census dates. This metadata item is used to measure waiting times at a designated census date whereas the metadata item Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] measures waiting times at removal.

The calculation of waiting times for patients who are transferred from an elective surgery waiting list managed by one public acute hospital to another will be investigated in the future. In this case, the amount of time waited on previous lists should follow the patient to the next. Therefore at the census date, their waiting time includes the total number of days on all lists (less days not ready for care and days in lower urgency categories).

This is a critical elective surgery waiting times metadata item. 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.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Is formed using Elective surgery waiting list episode—patient listing status, readiness for care code N Health, Standard 01/03/2005

Is formed using Hospital census (of elective surgery waitlist patients)—census date, DDMMYYYY Health, Standard 01/03/2005

Is formed using Elective care waiting list episode—listing date

for care, DDMMYYYY Health, Standard 01/03/2005

Is formed using Elective care waiting list episode—category reassignment date, DDMMYYYY Health, Standard 01/03/2005

Supersedes Waiting time at a census date, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.7 KB)

Is used in the formation of Elective surgery waiting list episode—overdue patient status, code N Health, Standard 01/03/2005

Is used in the formation of Elective surgery waiting list episode—extended wait patient indicator, code N Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Elective surgery waiting times (census data) NMDS Health, Superseded 07/12/2005

Implementation start date: 30/09/2002

Implementation end date: 30/06/2006

Elective surgery waiting times (census data) NMDS 2006-2009 Health, Superseded 03/12/2008

Implementation start date: 30/09/2006

Implementation end date: 31/03/2009

Elective surgery waiting times (census data) NMDS 2009- Health, Standard 03/12/2008

Implementation start date: 30/06/2009

Waiting time at removal from elective surgery waiting list

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—waiting time (at removal), total days N[NNN]
METeOR identifier:	269960
Registration status:	Health, Standard 01/03/2005
Definition:	The time elapsed (in days) 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 removed from the waiting list.
Context:	Elective surgery
Data Element Concept:	Elective surgery waiting list episode—waiting time

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:

The number of days is calculated by subtracting the listing date for care from the removal 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 removal.

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 removal, 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 removal) the number of days at the less urgent clinical urgency category should be calculated by subtracting the listing date for care 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 removal should be calculated by subtracting one category reassignment date from the subsequent category reassignment date, and then adding the days together.

When a patient is removed from an elective surgery waiting list, for admission on an elective basis for the procedure they were awaiting, 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 removal 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.

Comments:

Elective surgery waiting times data collections include measures of waiting times at removal and at designated census dates. This metadata item is used to measure waiting times at removal whereas the metadata item waiting time at a census date measures waiting times at a designated census date.

The calculation of waiting times for patients, who are transferred from an elective surgery waiting list managed by one public acute hospital to another, will be investigated in the future. In this case, the amount of time waited on previous lists would follow the patient to the next. Therefore when the patient is removed from the waiting list (for admission or other reason), their waiting time would include the total number of days on all lists (less days not ready for care and days in lower urgency categories).

This is a critical elective surgery waiting times metadata item. It is used to determine whether patients were overdue, or had extended waits when they were removed from the waiting list. 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.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Waiting time at removal from elective surgery waiting list, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.0 KB)

Is formed using Elective care waiting list episode—category reassignment date, DDMMYYYY Health, Standard 01/03/2005

Is formed using Elective surgery waiting list episode—waiting list removal date, DDMMYYYY Health, Standard 01/03/2005

Is formed using Episode of admitted patient care—admission date, DDMMYYYY Health, Standard 01/03/2005

Is formed using Elective care waiting list episode—listing date for care, DDMMYYYY Health, Standard 01/03/2005

Is used in the formation of Elective surgery waiting list episode—overdue patient status, code N Health, Standard 01/03/2005

Is used in the formation of Elective surgery waiting list episode—extended wait patient indicator, code N Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Elective surgery waiting times (removals data) NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2002

Implementation end date: 30/06/2006

Elective surgery waiting times (removals data) NMDS 2006-2009 Health, Superseded 03/12/2008

Implementation start date: 01/07/2006

Implementation end date: 30/06/2009

Elective surgery waiting times (removals data) NMDS 2009- Health, Standard 03/12/2008

Implementation start date: 01/07/2009

Weight (self-reported)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—weight (self-reported), total kilograms NN[N]
METeOR identifier:	302365
Registration status:	Health, Standard 14/07/2005
Definition:	A person's self-reported weight (body mass).
Data Element Concept:	Person—weight

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NN[N]
Maximum character length:	3

Supplementary values:

Value	Meaning
888	Unknown
999	Not stated

Unit of measure: Kilogram (Kg)

Collection and usage attributes

Guide for use:

CODE 888 Unknown

Use this code if self-reported body mass (weight) is unknown.

CODE 999 Not stated

Use this code if self-reported body mass (weight) is not responded to.

Data element attributes

Collection and usage attributes

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

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.

Comments:

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

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. Metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

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.

Weight

30 kg = Weight

35 kg = Weight

... in 5 kg categories

135 kg = Weight

Weight => 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.

Source and reference attributes

Origin:

National Centre for Monitoring Cardiovascular Disease

Australian Institute of Health and Welfare

National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Weight - self-reported, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (20.5 KB)

Supersedes Adult—weight (self-reported), total kilograms NN[N] Health, Superseded 14/07/2005

Is used in the formation of Child—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005

Is used in the formation of Adult—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Weight in grams (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—weight (measured), total grams NNNN
Synonymous names:	Infant weight, neonate, stillborn
METeOR identifier:	310245
Registration status:	Health, Standard 01/03/2005
Definition:	The weight (body mass) of a person measured in grams.
Data Element Concept:	Person—weight

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NNNN
Maximum character length:	4
Unit of measure:	Gram (g)

Data element attributes

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v 6) NN Health, Standard 22/12/2009 Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v 6) ANNA Health, Standard 22/12/2009 Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA Health, Superseded 22/12/2009 Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN Health, Superseded 22/12/2009
Implementation in Data Set Specifications:	Admitted patient care NMDS Health, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007

Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Conditional obligation:
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.

Weight in kilograms (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—weight (measured), total kilograms N[NN].N
Synonymous names:	Infant weight, neonate, stillborn
METeOR identifier:	270208
Registration status:	Health, Standard 01/03/2005
Definition:	The weight (body mass) of a person measured in kilograms.
Data Element Concept:	Person—weight

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN].N
Maximum character length:	4
Supplementary values:	Value Meaning 999.9 Not collected
Unit of measure:	Kilogram (Kg)
Unit of measure precision:	1

Collection and usage attributes

Guide for use:	A continuous variable measured to the nearest 0.1 kg. CODE 999.9 Not collected Use this code if measured weight is not collected.

Data element attributes

Collection and usage attributes

Guide for use:	In order to ensure consistency in measurement, the measurement protocol described under Collection methods should be used.
Collection methods:	The collection of anthropometric measurements, particularly in those who are overweight or obese or who are concerned about their weight, should be performed with great sensitivity and without drawing attention to an individual's weight. The measurement protocol described below is that recommended by the WHO Expert Committee (1995). 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. Scales should be capable of being calibrated across the entire range of measurements. Precision error should be no more than 0.1kg. Scales should be calibrated on each day of use. Manufacturers' guidelines should be followed with regard to the transportation of the scales.

Adults and children who can stand:

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.

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.

Infants:

Birth weight and gender should be recorded with gestational age. During infancy a levelled pan scale with a bean and movable weights or digital scales capable of measuring to two decimal places of a kilogram are acceptable. Birth weight should be determined within 12 hours of birth. The infant, with or without a nappy or diaper is placed on the scales so that the weight is distributed equally about the centre of the pan. When the infant is lying or suspended quietly, weight is recorded to the nearest 10 grams. If the nappy or diaper is worn, its weight is subtracted from the observed weight i.e. reference data for infants are based on nude weights.

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. It is recommended that the scale be calibrated at the extremes and in the mid range of the expected weight of the population being studied.

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.

Comments:

This metadata item applies to persons of all ages. 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.

Metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

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. However 5-year age groups are not generally suitable for children and adolescents. 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, women, children and adolescents, although the range will depend on the population.

Weight

10 kg = Weight

15 kg = Weight

... in 5 kg categories

135 kg = Weight

Weight => 140 kg

Source and reference attributes

Submitting organisation: World Health Organization The consortium to develop standard methods for the collection and collation of anthropometric data in children as part of the National Food and Nutrition Monitoring and Surveillance Project, funded by the Commonwealth Department of Health and Ageing

Reference documents: Clinical Guidelines on the Identification, Evaluation and Treatment of Overweight and Obesity in Adults (US National Heart, Lung and Blood Institute (NHLBI) in cooperation with the National Institute of Diabetes and Digestive and Kidney Diseases).

Chronic Diseases and Associated Risk Factors in Australia 2001 (AIHW).

Relational attributes

Related metadata references: Supersedes Weight - measured, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (29.3 KB)

Is used in the formation of Adult—body mass index (measured), ratio NN[N].N[N] Health, Standard 01/03/2005

Is used in the formation of Child—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005

Is used in the formation of Child—body mass index (measured), ratio NN[N].N[N] Health, Standard 01/03/2005

Is used in the formation of Adult—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009

Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Work sector—health professional

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—work sector in health profession, code N
METeOR identifier:	375388
Registration status:	Health, Standard 10/12/2009
Definition:	The sector in which a health professional works in their registered profession, as represented by a code.
Data Element Concept:	Registered health professional—work sector in registered health profession

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Public
2	Private

Data element attributes

Collection and usage attributes

Comments:

This data element is used to differentiate between establishments run by the government sector (code 1) and establishments that receive some government funding but are run by the non-government sector (code 2).

Code 1 Public

To be used when the establishment:

- operates from the public accounts of a Commonwealth, state or territory government or is part of the executive, judicial or legislative arms of government,
- is part of the general government sector or is controlled by some part of the general government sector,
- provides government services free of charge or at nominal prices, and
- is financed mainly from taxation.

Code 2 Private

To be used only when the establishment:

- is not controlled by government,

- is directed by a group of officers, an executive committee or a similar body elected by a majority of members, and
- may be an income tax exempt charity.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

Main job of registered chiropractor cluster Health, Standard 10/12/2009

Main job of registered dental and allied dental health professional cluster Health, Standard 10/12/2009

Main job of registered medical professional cluster Health, Standard 10/12/2009

Main job of registered midwife cluster Health, Standard 10/12/2009

Main job of registered nursing professional cluster Health, Standard 10/12/2009

Main job of registered optometrist cluster Health, Standard 10/12/2009

Main job of registered osteopath cluster Health, Standard 10/12/2009

Main job of registered pharmacist cluster Health, Standard 10/12/2009

Main job of registered physiotherapist cluster Health, Standard 10/12/2009

Main job of registered podiatrist cluster Health, Standard 10/12/2009

Main job of registered psychologist cluster Health, Standard 10/12/2009

Second job of registered chiropractor cluster Health, Standard 10/12/2009

Second job of registered dental and allied dental health professional cluster Health, Standard 10/12/2009

Second job of registered medical professional cluster Health, Standard 10/12/2009

Second job of registered midwife cluster Health, Standard 10/12/2009

Second job of registered nursing professional cluster Health, Standard 10/12/2009

Second job of registered optometrist cluster Health, Standard 10/12/2009

Second job of registered osteopath cluster Health, Standard 10/12/2009

Second job of registered pharmacist cluster Health, Standard 10/12/2009

Second job of registered physiotherapist cluster Health, Standard 10/12/2009

Second job of registered podiatrist cluster Health, Standard 10/12/2009

Second job of registered psychologist cluster Health, Standard 10/12/2009

Work setting hours cluster Health, Standard 10/12/2009

Work setting—chiropractor

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—work setting, chiropractor code ANN
METeOR identifier:	377909
Registration status:	Health, Standard 10/12/2009
Definition:	The type of health service setting or other organisation arrangement in which the work was undertaken by the chiropractor, as represented by a code.
Data Element Concept:	Registered health professional—work setting

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	ANN
Maximum character length:	3

Permissible values:

Value	Meaning
A01	Solo private practice
A02	Group private practice
A03	Locum private practice
B00	Aboriginal health service
C00	Community health care service
D00	Hospital
E00	Residential health care facility
F00	Commercial/business service
G00	Educational facility
H00	Correctional services
I00	Defence forces
J00	Other government department or agency
Y00	Other

Supplementary values:

Value	Meaning
Z99	Unknown/inadequately described/not stated

Collection and usage attributes

Guide for use:

CODE A01 SOLO PRIVATE PRACTICE

Solo private practice includes all private practices owned and operated by a single health practitioner, excluding locum practices.

CODE A02 GROUP PRIVATE PRACTICE

Group private practice includes all private practices owned and

operated by a partnership of more than one health practitioner excluding locum practices.

CODE A03 LOCUM PRIVATE PRACTICE

Locum private practice includes all private practices where the primary business of the practice is the provision of locum or relief services.

CODE B00 ABORIGINAL HEALTH SERVICE

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.

CODE C00 COMMUNITY HEALTH CARE SERVICE

Community health care services include ambulatory centres, day procedure centres and community health centres. This category excludes non-residential health care provided by private practices and the defence department.

CODE D00 HOSPITAL

Hospitals include acute care, psychiatric and dental hospitals as well as emergency departments and outpatient clinics. This category excludes hospitals provided by Defence Department.

CODE E00 RESIDENTIAL HEALTH CARE FACILITIES

Residential health care facilities include residential aged care, hospices, residential mental health care, residential drug rehabilitation and disability institutions.

CODE F00 COMMERCIAL/BUSINESS SERVICES

Commercial/business includes insurance providers, pathology laboratories, banks and pharmaceutical manufacturers, wholesalers and retailers. This category excludes private practices.

CODE G00 EDUCATIONAL FACILITY

Educational facilities include schools, universities, vocational education and training institutions.

CODE H00 CORRECTIONAL SERVICES

Correctional services include jails and detention centres.

CODE I00 DEFENCE FORCES

Defence forces include all facilities operated by the Australian Government Department of Defence.

CODE J00 OTHER GOVERNMENT DEPARTMENT OR AGENCY

Other government department or agency includes all government facilities not specified above including laboratories and research organisations.

CODE Y00 OTHER

Other includes all organisations not specified above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

Main job of registered chiropractor cluster Health, Standard 10/12/2009

Second job of registered chiropractor cluster Health, Standard 10/12/2009

Work setting—dental

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—work setting, dental code ANN
METeOR identifier:	377911
Registration status:	Health, Standard 10/12/2009
Definition:	The type of health service or other organisation in which the work was undertaken by the dental health professional, as represented by a code.
Data Element Concept:	Registered health professional—work setting

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	ANN
Maximum character length:	3

Permissible values:

Value	Meaning
A01	Solo private practice
A02	Group private practice
A03	Locum private practice
B00	Aboriginal health service
C05	Health promotion service
C07	Other community health care service
D00	Hospital
E00	Residential health care facility
F00	Commercial/business service
G01	Tertiary educational facility
G02	School
G03	Other educational facility
H00	Correctional services
I00	Defence forces
J00	Other government department or agency
Y00	Other

Supplementary values:

Value	Meaning
Z99	Unknown/inadequately described/not stated

Collection and usage attributes

Guide for use:	CODE A01 SOLO PRIVATE PRACTICE Solo private practice includes all private practices owned and operated by a single health practitioner, excluding locum practices.

CODE A02 GROUP PRIVATE PRACTICE

Group private practice includes all private practices owned and operated by a partnership of more than one health practitioner excluding locum practices.

CODE A03 LOCUM PRIVATE PRACTICE

Locum private practice includes all private practices where the primary business of the practice is the provision of locum or relief services.

CODE B00 ABORIGINAL HEALTH SERVICE

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.

CODE C05 HEALTH PROMOTION SERVICE

Health promotion service includes those services primarily engaged in the provision of information and education to improve dental health and prevent disease.

CODE C07 OTHER COMMUNITY HEALTH CARE SERVICE

Other community health care service includes all non-residential health care services not mentioned above.

CODE D00 HOSPITAL

Hospitals include acute care, psychiatric and dental hospitals as well as emergency departments and outpatient clinics. This category excludes hospitals provided by Defence Department.

CODE E00 RESIDENTIAL HEALTH CARE FACILITIES

Residential health care facilities include residential aged care, hospices, residential mental health care, residential drug rehabilitation and disability institutions.

CODE F00 COMMERCIAL/BUSINESS SERVICES

Commercial/business includes insurance providers, pathology laboratories, banks and pharmaceutical manufacturers, wholesalers and retailers. This category excludes private practices.

CODE G01 TERTIARY EDUCATIONAL FACILITY

Tertiary educational facility includes all educational institutions mainly engaged in providing undergraduate or postgraduate teaching, or vocational education and training.

CODE G02 SCHOOL

Schools include all pre-primary, primary and secondary schools.

CODE G03 OTHER EDUCATIONAL FACILITY

Other educational facility includes all organisations primarily involved in the delivery of education and training but not mentioned above.

CODE H00 CORRECTIONAL SERVICES

Correctional services include jails and detention centres.

CODE I00 DEFENCE SERVICES

Defence forces include all facilities operated by the Australian

Government Department of Defence.

CODE J00 OTHER GOVERNMENT DEPARTMENT OR AGENCY

Other government department or agency includes all government facilities not specified above including laboratories and research organisations.

CODE Y00 OTHER

Other includes all organisations not specified above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

Main job of registered dental and allied dental health professional cluster Health, Standard 10/12/2009

Second job of registered dental and allied dental health professional cluster Health, Standard 10/12/2009

Work setting—medical practitioner

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—work setting, medical practitioner code ANN
METeOR identifier:	377814
Registration status:	Health, Standard 10/12/2009
Definition:	The type of service setting or other organisation arrangement in which health care was delivered by the medical practitioner, as represented by a code.
Data Element Concept:	Registered health professional—work setting

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	ANN
Maximum character length:	3

Permissible values:

Value	Meaning
A01	Solo private practice
A02	Group private practice
A03	Locum private practice
B00	Aboriginal health service
C02	Community mental health service
C03	Community drug and alcohol service
C07	Other community health care services
D01	Outpatient services
D02	Other hospital services
E02	Residential mental health care services
E05	Other residential health care facility
F00	Commercial/business services
G01	Tertiary educational facility
G02	School
G03	Other educational facility
H00	Correctional services
I00	Defence forces
J00	Other government department or agency
Y00	Other

Supplementary values:

Value	Meaning
Z99	Unknown/inadequately described/not stated

Collection and usage attributes

Guide for use:

CODE A01 SOLO PRIVATE PRACTICE

Solo private practice includes all private practices owned and operated by a single health practitioner, excluding locum practices.

CODE A02 GROUP PRIVATE PRACTICE

Group private practice includes all private practices owned and operated by a partnership of more than one health practitioner excluding locum practices.

CODE A03 LOCUM PRIVATE PRACTICE

Locum private practice includes all private practices where the primary business of the practice is the provision of locum or relief services.

CODE B00 ABORIGINAL HEALTH SERVICE

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.

CODE C02 COMMUNITY MENTAL HEALTH SERVICE

Community mental health service includes all non-residential health care services that engage primarily in mental health care.

CODE C03 COMMUNITY DRUG AND ALCOHOL SERVICE

Community drug and alcohol service includes all non-residential health care services that engage primarily in drug and alcohol treatment.

CODE C07 OTHER COMMUNITY HEALTH CARE SERVICES

Other community health care service includes all non-residential health care services not mentioned above.

CODE D01 OUTPATIENT SERVICES

Outpatient services include all hospital-based clinics that provide specialist outpatient services to non-admitted, non-emergency department patients.

CODE D02 OTHER HOSPITAL SERVICE

This category includes all other hospital services including acute care, psychiatric and dental hospitals, as well as emergency departments. It excludes hospitals provided by Defence Department

CODE E02 RESIDENTIAL MENTAL HEALTH CARE SERVICES

Residential mental health care services include all residential health care services that primarily engage in the delivery of specialist mental health care.

CODE E05 OTHER RESIDENTIAL HEALTH CARE FACILITY

This category includes all other residential health care facilities not specified above.

CODE F00 COMMERCIAL/BUSINESS SERVICES

Commercial/business includes insurance providers, pathology laboratories, banks and pharmaceutical manufacturers, wholesalers and retailers. This category excludes private practices

CODE G01 TERTIARY EDUCATIONAL FACILITY

Tertiary educational facility includes all educational institutions mainly engaged in providing undergraduate or postgraduate teaching, or vocational education and training.

CODE G02 SCHOOL

Schools include all pre-primary, primary and secondary schools.

CODE G03 OTHER EDUCATIONAL FACILITY

Other educational facility includes all organisations primarily involved in the delivery of education and training but not mentioned above.

CODE H00 CORRECTIONAL SERVICES

Correctional services include jails and detention centres.

CODE I00 DEFENCE FORCES

Defence forces include all facilities operated by the Australian Government Department of Defence.

CODE J00 OTHER GOVERNMENT DEPARTMENT OR AGENCY

Other government department or agency includes all government facilities not specified above including laboratories and research organisations.

CODE Y00 OTHER

Other includes all organisations not specified above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

Main job of registered medical professional cluster Health, Standard 10/12/2009

Second job of registered medical professional cluster Health, Standard 10/12/2009

Work setting—midwife

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—work setting, midwife code ANN
METeOR identifier:	380121
Registration status:	Health, Standard 10/12/2009
Definition:	The type of health service setting or other organisation arrangement in which the health care was delivered by the midwife, as represented by a code.
Data Element Concept:	Registered health professional—work setting

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	ANN
Maximum character length:	3

Permissible values:

Value	Meaning
A03	Locum private practice
A06	Other private practice
B00	Aboriginal health service
C00	Community health care service
D01	Outpatient service
D02	Other hospital service
G01	Tertiary educational facility
Y00	Other

Supplementary values:

Z99	Unknown/inadequately described/not stated

Collection and usage attributes

Guide for use:

CODE A03 LOCUM PRIVATE PRACTICE

Locum private practice includes all private practices where the primary business of the practice is the provision of locum or relief services.

CODE A06 OTHER PRIVATE PRACTICE

Other private practice includes all other private practices not included above.

CODE B00 ABORIGINAL HEALTH SERVICE

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.

CODE C00 COMMUNITY HEALTH CARE SERVICE

Community health care services include ambulatory centres, day procedure centres and community health centres. This category excludes non-residential health care provided by private practices and the defence department, and aboriginal health services.

CODE D01 OUTPATIENT SERVICES

Outpatient services include all hospital-based clinics that provide specialist outpatient services to non-admitted, non-emergency department patients.

CODE D02 OTHER HOSPITAL SERVICE

This category includes all other hospital services including acute care, psychiatric and dental hospitals, as well as emergency departments. It excludes hospitals provided by Defence Department.

CODE G01 TERTIARY EDUCATIONAL FACILITY

Tertiary educational facility includes all educational institutions mainly engaged in providing undergraduate or postgraduate teaching, or vocational education and training.

CODE Y00 OTHER

Other includes all organisations not specified above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

Main job of registered midwife cluster Health, Standard 10/12/2009

Second job of registered midwife cluster Health, Standard 10/12/2009

Work setting—nurse

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—work setting, nurse code ANN
METeOR identifier:	377913
Registration status:	Health, Standard 10/12/2009
Definition:	The type of health service setting or other organisation arrangement in which the health care was delivered by the nursing professional, as represented by a code.
Data Element Concept:	Registered health professional—work setting

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	ANN
Maximum character length:	3

Permissible values:

Value	Meaning
A03	Locum private practice
A05	General Practitioner (GP) practice
A06	Other private practice
B00	Aboriginal health service
C02	Community mental health service
C03	Community drug and alcohol service
C07	Other community health care service
D01	Outpatient service
D02	Other hospital service
E01	Residential aged care facility
E02	Residential mental health care service
E04	Hospice
E05	Other residential health care facility
F00	Commercial/business service
G01	Tertiary educational facility
G02	School
G03	Other educational facility
H00	Correctional services
I00	Defence forces
J00	Other government agency or department
Y00	Other

Supplementary values:

Value	Meaning
Z99	Unknown/inadequately described/not stated

Collection and usage attributes

Guide for use:

CODE A03 LOCUM PRIVATE PRACTICE

Locum private practice includes all private practices where the primary business of the practice is the provision of locum or relief services.

CODE A05 GENERAL PRACTITIONER (GP) PRACTICE

General Practitioner (GP) practice includes all solo, group and other GP private practices.

CODE A06 OTHER PRIVATE PRACTICE

Other private practice includes all other private practices not included above.

CODE B00 ABORIGINAL HEALTH SERVICE

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.

CODE C02 COMMUNITY MENTAL HEALTH SERVICE

Community mental health service includes all non-residential health care services that engage primarily in mental health care.

CODE C03 COMMUNITY DRUG AND ALCOHOL SERVICE

Community drug and alcohol service includes all non-residential health care services that engage primarily in drug and alcohol treatment.

CODE C07 OTHER COMMUNITY HEALTH CARE SERVICES

Other community health care services include all non-residential health care services not mentioned above.

CODE D01 OUTPATIENT SERVICE

Outpatient services include all hospital-based clinics that provide specialist outpatient services to non-admitted, non-emergency department patients.

CODE D02 OTHER HOSPITAL SERVICE

This category includes all other hospital services including acute care, psychiatric and dental hospitals, as well as emergency departments. It excludes hospitals provided by Defence Department.

CODE E01 RESIDENTIAL AGED CARE FACILITIES

Residential aged care facilities include all residential health care facilities that primarily engage in the delivery of aged health care.

CODE E02 RESIDENTIAL MENTAL HEALTH CARE SERVICES

Residential mental health care services include all residential health care services that primarily engage in the delivery of specialist mental health care.

CODE E04 HOSPICE

Hospice includes all residential facilities primarily designed to provide palliative care for terminally ill patients.

CODE E05 OTHER RESIDENTIAL HEALTH CARE FACILITY

This category includes all other residential health care facilities not specified above.

CODE F00 COMMERCIAL/BUSINESS

Commercial/business includes insurance providers, pathology laboratories, banks and pharmaceutical manufacturers, wholesalers and retailers. This category excludes private practices.

CODE G01 TERTIARY EDUCATIONAL FACILITY

Tertiary educational facility includes all educational institutions mainly engaged in providing undergraduate or postgraduate teaching, or vocational education and training.

CODE G02 SCHOOL

Schools include all pre-primary, primary and secondary schools.

CODE G03 OTHER EDUCATIONAL FACILITY

Other educational facility includes all organisations primarily involved in the delivery of education and training but not mentioned above.

CODE H00 CORRECTIONAL SERVICES

Correctional services include jails and detention centres.

CODE I00 DEFENCE FORCES

Defence forces include all facilities operated by the Australian Government Department of Defence.

CODE J00 OTHER GOVERNMENT DEPARTMENT OR AGENCY

Other government department or agency includes all government facilities not specified above including laboratories and research organisations.

CODE Y00 OTHER

Other includes all organisations not specified above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: Nursing professionals include enrolled nurses, registered nurses and nurse practitioners.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Main job of registered nursing professional cluster Health, Standard 10/12/2009

Second job of registered nursing professional cluster Health, Standard 10/12/2009

Work setting—optometrist

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—work setting, optometrist code ANN
METeOR identifier:	377915
Registration status:	Health, Standard 10/12/2009
Definition:	The type of health service setting or other organisation arrangement in which the health care was delivered by the optometrist, as represented by a code.
Data Element Concept:	Registered health professional—work setting

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	ANN
Maximum character length:	3

Permissible values:

Value	Meaning
A01	Solo private practice
A02	Group private practice
A03	Locum private practice
B00	Aboriginal health service
C00	Community health care service
D00	Hospital
E00	Residential health care facility
F00	Commercial/business services
G00	Educational facility
H00	Correctional services
I00	Defence forces
J00	Other government department or agency
Y00	Other

Supplementary values:

Z99	Unknown/inadequately described/not stated

Collection and usage attributes

Guide for use:

CODE A01 SOLO PRIVATE PRACTICE

Solo private practice includes all private practices owned and operated by a single health practitioner, excluding locum practices.

CODE A02 GROUP PRIVATE PRACTICE

Group private practice includes all private practices owned and

operated by a partnership of more than one health practitioner excluding locum practices.

CODE A03 LOCUM PRIVATE PRACTICE

Locum private practice includes all private practices where the primary business of the practice is the provision of locum or relief services.

CODE B00 ABORIGINAL HEALTH SERVICE

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.

CODE C00 COMMUNITY HEALTH CARE SERVICES

Community health care services include ambulatory centres, day procedure centres and community health centres. This category excludes non-residential health care provided by private practices and the defence department.

CODE D00 HOSPITAL

Hospitals include acute care, psychiatric and dental hospitals as well as emergency departments and outpatient clinics. This category excludes hospitals provided by Defence Department.

CODE E00 RESIDENTIAL HEALTH CARE FACILITIES

Residential health care facilities include residential aged care, hospices, residential mental health care, residential drug rehabilitation and disability institutions.

CODE F00 COMMERCIAL/BUSINESS SERVICES

Commercial/business includes insurance providers, pathology laboratories, banks and pharmaceutical manufacturers, wholesalers and retailers. This category excludes private practices.

CODE G00 EDUCATIONAL FACILITY

Educational facility includes schools, universities, vocational education and training institutions.

CODE H00 CORRECTIONAL SERVICES

Correctional services include jails and detention centres.

CODE I00 DEFENCE FORCES

Defence forces include all facilities operated by the Australian Government Department of Defence.

CODE J00 OTHER GOVERNMENT DEPARTMENT OR AGENCY

Other government department or agency includes all government facilities not specified above including laboratories and research organisations.

CODE Y00 OTHER

Other includes all organisations not specified above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

Main job of registered optometrist cluster Health, Standard 10/12/2009

Second job of registered optometrist cluster Health, Standard 10/12/2009

Work setting—osteopath

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—work setting, osteopath code ANN
METeOR identifier:	377917
Registration status:	Health, Standard 10/12/2009
Definition:	The type of health service setting or other organisation arrangement in which the health care was delivered by the osteopath, as represented by a code.
Data Element Concept:	Registered health professional—work setting

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	ANN
Maximum character length:	3

Permissible values:

Value	Meaning
A01	Solo private practice
A02	Group private practice
A03	Locum private practice
B00	Aboriginal health service
C00	Community health care service
D00	Hospital
E00	Residential health care facility
F00	Commercial/business service
G00	Educational facility
H00	Correctional services
I00	Defence forces
J00	Other government department or agency
Y00	Other

Supplementary values:

Z99	Unknown/inadequately described/not stated

Collection and usage attributes

Guide for use:

CODE A01 SOLO PRIVATE PRACTICE

Solo private practice includes all private practices owned and operated by a single health practitioner, excluding locum practices.

CODE A02 GROUP PRIVATE PRACTICE

Group private practice includes all private practices owned and

operated by a partnership of more than one health practitioner excluding locum practices.

CODE A03 LOCUM PRIVATE PRACTICE

Locum private practice includes all private practices where the primary business of the practice is the provision of locum or relief services.

CODE B00 ABORIGINAL HEALTH SERVICE

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.

CODE C00 COMMUNITY HEALTH CARE SERVICES

Community health care services include ambulatory centres, day procedure centres and community health centres. This category excludes non-residential health care provided by private practices and the defence department, and Aboriginal health services.

CODE D00 HOSPITAL

Hospitals include acute care, psychiatric and dental hospitals as well as emergency departments and outpatient clinics. This category excludes hospitals provided by Defence Department.

CODE E00 RESIDENTIAL HEALTH CARE FACILITIES

Residential health care facilities include residential aged care, hospices, residential mental health care, residential drug rehabilitation and disability institutions.

CODE F00 COMMERCIAL/BUSINESS SERVICES

Commercial/business includes insurance providers, pathology laboratories, banks and pharmaceutical manufacturers, wholesalers and retailers. This category excludes private practices.

CODE G00 EDUCATIONAL FACILITY

Educational facility includes schools, universities, vocational education and training institutions.

CODE H00 CORRECTIONAL SERVICES

Correctional services include jails and detention centres.

CODE I00 DEFENCE FORCES

Defence forces include all facilities operated by the Australian Government Department of Defence.

CODE J00 OTHER GOVERNMENT DEPARTMENT OR AGENCY

Other government department or agency includes all government facilities not specified above including laboratories and research organisations.

CODE Y00 OTHER

Other includes all organisations not specified above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

Main job of registered osteopath cluster Health, Standard 10/12/2009

Second job of registered osteopath cluster Health, Standard 10/12/2009

Work setting—pharmacist

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—work setting, pharmacist code ANN
METeOR identifier:	377919
Registration status:	Health, Standard 10/12/2009
Definition:	The type of health service setting or other organisation arrangement in which the health care was delivered by the pharmacist, as represented by a code.
Data Element Concept:	Registered health professional—work setting

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	ANN
Maximum character length:	3

Permissible values:

Value	Meaning
A04	Medical centre
A06	Other private practice
B00	Aboriginal health service
C00	Community health care service
D00	Hospital
E00	Residential health care facility
F01	Retail pharmacy
F02	Wholesale pharmacy
F03	Pharmaceutics manufacturing
F05	Other commercial/business
G00	Educational facility
H00	Correctional services
I00	Defence forces
J00	Other government department or agency
Y00	Other

Supplementary values:

Value	Meaning
Z99	Unknown/inadequately described/not stated

Collection and usage attributes

Guide for use: CODE A04 MEDICAL PRACTICE

Medical practice includes all forms of private medical practice including medical centres.

CODE A06 OTHER PRIVATE PRACTICE

Other private practice includes all other private practices not included above.

CODE B00 ABORIGINAL HEALTH SERVICE

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.

CODE C00 COMMUNITY HEALTH CARE SERVICES

Community health care services include ambulatory centres, day procedure centres and community health centres. This category excludes non-residential health care provided by private practices and the defence department, and aboriginal health services.

CODE D00 HOSPITAL

Hospitals include acute care, psychiatric and dental hospitals as well as emergency departments and outpatient clinics. This category excludes hospitals provided by Defence Department.

CODE E00 RESIDENTIAL HEALTH CARE FACILITIES

Residential health care facilities include residential aged care, hospices, residential mental health care, residential drug rehabilitation and disability institutions.

CODE F01 RETAIL PHARMACY

Businesses mainly engaged in retailing prescription drugs or patent medicines, cosmetics and/or toiletries.

CODE F02 WHOLESALE PHARMACY

Businesses mainly engaged in wholesaling prescription drugs or patent medicines, cosmetics or toiletries.

CODE F03 PHARMACEUTICS MANUFACTURING

Businesses mainly engaged in manufacturing pharmaceutical and medicinal products. It also includes businesses mainly engaged in manufacturing diagnostic substances for antibodies, antigens and chemical/diagnostic testing agents.

CODE F05 OTHER COMMERCIAL/BUSINESS

Other commercial/business includes all other commercial/business settings not included above.

CODE G00 EDUCATIONAL FACILITY

Educational facility includes schools, universities, vocational education and training institutions.

CODE H00 CORRECTIONAL SERVICES

Correctional services include jails and detention centres.

CODE I00 DEFENCE FORCES

Defence forces include all facilities operated by the Australian Government Department of Defence.

CODE J00 OTHER GOVERNMENT DEPARTMENT OR AGENCY

Other government department or agency includes all

government facilities not specified above including laboratories and research organisations.

CODE Y00 OTHER

Other includes all organisations not specified above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

Main job of registered pharmacist cluster Health, Standard 10/12/2009

Second job of registered pharmacist cluster Health, Standard 10/12/2009

Work setting—physiotherapist

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—work setting, physiotherapist code ANN
METeOR identifier:	377921
Registration status:	Health, Standard 10/12/2009
Definition:	The type of health service setting or other organisation arrangement in which the health care was delivered by the physiotherapist, as represented by a code.
Data Element Concept:	Registered health professional—work setting

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	ANN
Maximum character length:	3

Permissible values:

Value	Meaning
A01	Solo private practice
A02	Group private practice
A03	Locum private practice
B00	Aboriginal health service
C01	Domiciliary service
C06	Rehabilitation/physical developmental service
C07	Other community health care service
D01	Outpatient service
D02	Other hospital service
E01	Residential aged care facility
E05	Other residential health care facility
F04	Sports centre/clinic
F05	Other commercial/business service
G00	Educational facility
H00	Correctional services
I00	Defence forces
J00	Other government department or agency
Y00	Other

Supplementary values:

Z99	Unknown/inadequately described/not stated

Collection and usage attributes

Guide for use:

CODE A01 SOLO PRIVATE PRACTICE

Solo private practice includes all private practices owned and operated by a single health practitioner, excluding locum practices.

CODE A02 GROUP PRIVATE PRACTICE

Group private practice includes all private practices owned and operated by a partnership of more than one health practitioner excluding locum practices.

CODE A03 LOCUM PRIVATE PRACTICE

Locum private practice includes all private practices where the primary business of the practice is the provision of locum or relief services.

CODE B00 ABORIGINAL HEALTH SERVICE

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people

CODE C01 DOMICILIARY SERVICE

Domiciliary service includes all services primarily providing nursing or other professional paramedical care or treatment and non-qualified domestic assistance to people in their own homes.

CODE C06 REHABILITATION/PHYSICAL DEVELOPMENT SERVICE

Rehabilitation/physical development service includes all organisations that primarily engage in specialist rehabilitation and physical development assistance services.

CODE C07 OTHER COMMUNITY HEALTH CARE SERVICES

Other community health care services includes all non-residential health care services not mentioned above.

CODE D01 OUTPATIENT SERVICE

Outpatient services include all hospital-based clinics that provide specialist outpatient services to non-admitted, non-emergency department patients.

CODE D02 OTHER HOSPITAL SERVICE

This category includes all other hospital services including acute care, psychiatric and dental hospitals, as well as emergency departments. It excludes hospitals provided by Defence Department.

CODE E01 RESIDENTIAL AGED CARE FACILITIES

Residential aged care facilities include all residential health care facilities that primarily engage in the delivery of aged health care.

CODE E05 OTHER RESIDENTIAL HEALTH CARE FACILITY

This category includes all other residential health care facilities not specified above.

CODE F04 SPORTS CENTRE/CLINIC

Sports centres/clinics primarily provide professional services for

the prevention and treatment of injuries and diseases related to participation in sports.

CODE F05 OTHER COMMERCIAL/BUSINESS SERVICE

Other commercial/business includes all other commercial/business settings not included above

CODE G00 EDUCATIONAL FACILITY

Educational facility includes schools, universities, vocational education and training institutions.

CODE H00 CORRECTIONAL SERVICES

Correctional services include jails and detention centres.

CODE I00 DEFENCE FORCES

Defence forces include all facilities operated by the Australian Government Department of Defence.

CODE J00 OTHER GOVERNMENT DEPARTMENT OR AGENCY

Other government department or agency includes all government facilities not specified above including laboratories and research organisations.

CODE Y00 OTHER

Other includes all organisations not specified above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

Main job of registered physiotherapist cluster Health, Standard 10/12/2009

Second job of registered physiotherapist cluster Health, Standard 10/12/2009

Work setting—podiatrist

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—work setting, podiatrist code ANN
METeOR identifier:	377923
Registration status:	Health, Standard 10/12/2009
Definition:	The type of health service setting or other organisation arrangement in which the health care was delivered by the podiatrist, as represented by a code.
Data Element Concept:	Registered health professional—work setting

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	ANN
Maximum character length:	3

Permissible values:

Value	Meaning
A01	Solo private practice
A02	Group private practice
A03	Locum private practice
B00	Aboriginal health service
C06	Rehabilitation/physical developmental service
C07	Other community health care service
D01	Outpatient service
D02	Other hospital service
E01	Residential aged care facility
E03	Disability institution
E04	Hospice
E05	Other residential health care service
F04	Sports centre/clinic
F05	Other commercial/business service
G00	Educational facility
H00	Correctional services
I00	Defence forces
J00	Other government department or agency
Y00	Other

Supplementary values:

Z99	Unknown/inadequately described/not stated

Collection and usage attributes

Guide for use:

CODE A01 SOLO PRIVATE PRACTICE

Solo private practice includes all private practices owned and operated by a single health practitioner, excluding locum practices.

CODE A02 GROUP PRIVATE PRACTICE

Group private practice includes all private practices owned and operated by a partnership of more than one health practitioner excluding locum practices.

CODE A03 LOCUM PRIVATE PRACTICE

Locum private practice includes all private practices where the primary business of the practice is the provision of locum or relief services.

CODE B00 ABORIGINAL HEALTH SERVICE

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.

CODE C06 REHABILITATION/PHYSICAL DEVELOPMENTAL SERVICE

Rehabilitation/physical development service includes all organisations that primarily engage in specialist rehabilitation and physical development assistance services.

CODE C07 OTHER COMMUNITY HEALTH CARE SERVICE

Other community health care service includes all non-residential health care services not mentioned above.

CODE D01 OUTPATIENT SERVICE

Outpatient services include all hospital-based clinics that provide specialist outpatient services to non-admitted, non-emergency department patients.

CODE D02 OTHER HOSPITAL SERVICE

This category includes all other hospital services including acute care, psychiatric and dental hospitals, as well as emergency departments. It excludes hospitals provided by Defence Department.

CODE E01 RESIDENTIAL AGED CARE FACILITY

Residential aged care facilities include all residential health care facilities that primarily engage in the delivery of aged health care.

CODE E03 DISABILITY INSTITUTION

Disability institution includes all residential services that primarily engage in the delivery of disability support services.

CODE E04 HOSPICE

Hospice includes all residential facilities primarily designed to provide palliative care for terminally ill patients.

CODE E05 OTHER RESIDENTIAL HEALTH CARE FACILITY

This category includes all other residential health care facilities not specified above.

CODE F04 SPORTS CENTRE/CLINIC

Sports centres/clinics primarily provide professional services for the prevention and treatment of injuries and diseases related to participation in sports.

CODE F05 OTHER COMMERCIAL/BUSINESS

Other commercial/business includes all other commercial/business settings not included above.

CODE G00 EDUCATIONAL FACILITY

Educational facility includes schools, universities, vocational education and training institutions.

CODE H00 CORRECTIONAL SERVICES

Correctional services include jails and detention centres.

CODE I00 DEFENCE FORCES

Defence forces include all facilities operated by the Australian Government Department of Defence.

CODE J00 OTHER GOVERNMENT DEPARTMENT OR AGENCY

Other government department or agency includes all government facilities not specified above including laboratories and research organisations.

CODE Y00 OTHER

Other includes all organisations not specified above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

Main job of registered podiatrist cluster Health, Standard 10/12/2009

Second job of registered podiatrist cluster Health, Standard 10/12/2009

Work setting—psychologist

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—work setting, psychologist code ANN
METeOR identifier:	377925
Registration status:	Health, Standard 10/12/2009
Definition:	The type of health service setting or other organisation arrangement in which the health care was delivered by the psychologist, as represented by a code.
Data Element Concept:	Registered health professional—work setting

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	ANN
Maximum character length:	3

Permissible values:

Value	Meaning
A01	Solo private practice
A02	Group private practice
A05	General practitioner (GP) practice
A06	Other private practice
B00	Aboriginal health service
C02	Community mental health service
C04	Drug and alcohol service
C06	Rehabilitation/physical developmental service
C07	Other community health care service
D00	Hospital
E03	Disability institution
E05	Other residential health care facility
F05	Commercial/business service
G01	Tertiary educational facility
G02	School
G03	Other educational facility
H00	Correctional services
I00	Defence forces
J00	Other government department or agency
Y00	Other

Supplementary values:

Value	Meaning
Z99	Unknown/inadequately described/not stated

Collection and usage attributes

Guide for use:

CODE A01 SOLO PRIVATE PRACTICE

Solo private practice includes all private practices owned and operated by a single health practitioner, excluding locum practices.

CODE A02 GROUP PRIVATE PRACTICE

Group private practice includes all private practices owned and operated by a partnership of more than one health practitioner excluding locum practices.

CODE A05 GENERAL PRACTITIONER (GP) PRACTICE

General Practitioner (GP) practice includes all solo, group and other GP private practices.

CODE A06 OTHER PRIVATE PRACTICE

Other private practice includes all other private practices not included above.

CODE B00 ABORIGINAL HEALTH SERVICE

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.

CODE C02 COMMUNITY MENTAL HEALTH

Community mental health service includes all non-residential health care services that engage primarily in mental health care.

CODE C04 DRUG AND ALCOHOL SERVICE

Drug and alcohol service includes all non-residential health care services that engage primarily in drug and alcohol treatment.

CODE C06 REHABILITATION/PHYSICAL DEVELOPMENTAL SERVICE

Rehabilitation/physical development service includes all organisations that primarily engage in specialist rehabilitation and physical development assistance services.

CODE C07 OTHER COMMUNITY HEALTH CARE SERVICE

Other community health care service includes all non-residential health care services not mentioned above.

CODE D00 HOSPITAL

Hospitals include acute care, psychiatric and dental hospitals as well as emergency departments and outpatient clinics. This category excludes hospitals provided by Defence Department.

CODE E03 DISABILITY INSTITUTION

Disability institution includes all residential services that primarily engage in the delivery of disability support services.

CODE E05 OTHER RESIDENTIAL HEALTH CARE FACILITY

This category includes all other residential health care facilities not specified above.

CODE F00 COMMERCIAL/BUSINESS SERVICES

Commercial/business includes insurance providers, pathology

laboratories, banks and pharmaceutical manufacturers, wholesalers and retailers. This category excludes private practices.

CODE G01 TERTIARY EDUCATIONAL FACILITY

Tertiary educational facility includes all educational institutions mainly engaged in providing undergraduate or postgraduate teaching, or vocational education and training.

CODE G02 SCHOOL

Schools include all pre-primary, primary and secondary schools.

CODE G03 OTHER EDUCATIONAL FACILITY

Other educational facility includes all organisations primarily involved in the delivery of education and training but not mentioned above.

CODE H00 CORRECTIONAL SERVICES

Correctional services include jails and detention centres.

CODE I00 DEFENCE FORCES

Defence forces include all facilities operated by the Australian Government Department of Defence.

CODE J00 OTHER GOVERNMENT DEPARTMENT OR AGENCY

Other government department or agency includes all government facilities not specified above including laboratories and research organisations.

CODE Y00 OTHER

Other includes all organisations not specified above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

Main job of registered psychologist cluster Health, Standard 10/12/2009

Second job of registered psychologist cluster Health, Standard 10/12/2009

Work setting—registered health professional

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Registered health professional—work setting, code ANN
METeOR identifier:	375402
Registration status:	Health, Standard 10/12/2009
Definition:	The type of health service setting or other organisation arrangement in which health care was delivered by the registered health professional, as represented by a code.
Data Element Concept:	Registered health professional—work setting

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	ANN
Maximum character length:	3

Permissible values:

Value	Meaning
A00	Private practice
B00	Aboriginal health service
C00	Community health care service
D00	Hospital
E00	Residential health care facility
F00	Commercial/business services
G00	Educational facility
H00	Correctional services
I00	Defence forces
J00	Other government department or agency
Y00	Other

Supplementary values:

Value	Meaning
Z99	Unknown/inadequately described/not stated

Collection and usage attributes

Guide for use:

CODE A00 PRIVATE PRACTICE

Private practice includes private practitioner rooms/ surgeries and 24-hour medical clinics.

CODE B00 ABORIGINAL HEALTH SERVICES

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.

CODE C00 COMMUNITY HEALTH CARE SERVICES

Community health care services include ambulatory centres, day

procedure centres and community health centres. This category excludes aboriginal health services and non-residential health care provided by private practices and the Australian Government Department of Defence.

CODE D00 HOSPITALS

Hospitals include acute care, psychiatric and dental hospitals as well as emergency departments and outpatient clinics. This category excludes hospitals provided by Defence Department.

CODE E00 RESIDENTIAL HEALTH CARE FACILITIES

Residential health care facilities include residential aged care, hospices, residential mental health care, residential drug rehabilitation and disability institutions.

CODE F00 COMMERCIAL/BUSINESS SERVICES

Commercial/business services include insurance providers, pathology laboratories, banks and pharmaceutical manufacturers, wholesalers and retailers. This category excludes private practices.

CODE G00 EDUCATIONAL FACILITY

Educational facilities include schools, universities, vocational education and training institutions.

CODE H00 CORRECTIONAL SERVICES

Correctional services include jails and detention centres.

CODE I00 DEFENCE FORCES

Defence forces include all facilities operated by the Australian Government Department of Defence.

CODE J00 OTHER GOVERNMENT DEPARTMENT OR AGENCY

Other government department or agency includes all government facilities not specified above including laboratories and research organisations.

CODE Y00 OTHER

Other includes all organisations not specified above.

Comments: This data element is used in conjunction with work sector and hours worked to collect data on the distribution of hour worked by registered health professionals.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Comments: This data element is used in conjunction with work sector and hours worked to collect data on the distribution of hours worked by registered health professionals.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Health professional—establishment type (employment), industry code NN Health, Superseded 10/12/2009

Implementation in Data Set Specifications: Work setting hours cluster Health, Standard 10/12/2009

Working partnership indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—working partnership indicator, yes/no code N
METeOR identifier:	290696
Registration status:	Health, Standard 05/12/2007
Definition:	Whether a service provider organisation has formal working partnership(s) with other service provider(s) or organisation(s), as represented by a code.
Data Element Concept:	Service provider organisation—working partnership indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

A formal working partnership involves arrangements between a service provider organisation and another service provider or organisation, aimed at providing integrated and seamless care, so that clients are able to move smoothly between services and service settings.

A formal working partnership is a verbal or written agreement between two or more parties. It specifies the roles and responsibilities of each party, including the expected outcomes of the agreement.

Key elements of a formal working partnership are that it is organised, routine, collaborative, and systematic. It excludes ad hoc arrangements. Examples of formal working partnerships include the existence of: written service agreements; formal liaison; referral and discharge planning processes; formal and routine consultation; protocols; partnership working groups; memoranda of understanding with other providers; and case conferencing.

CODE 1 Yes
The service provider organisation has formal working

partnership(s) with other service provider(s) or organisation(s) in place.

CODE 2 No
The service provider organisation has no formal working partnership(s) with other service provider(s) or organisation(s) in place.

Collection methods: Record only one code.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications: Palliative care performance indicators DSS Health, Standard 05/12/2007

Year insulin started

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—insulin start date, YYYY
METeOR identifier:	269928
Registration status:	Health, Standard 01/03/2005
Definition:	The year the patient started insulin injections.
Context:	Public health, health care and clinical settings.
Data Element Concept:	Patient—insulin start date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	YYYY
Maximum character length:	4

Data element attributes

Collection and usage attributes

Guide for use:	Record the year that insulin injections were started. This data element has to be completed for all patients who use insulin. It is used to cross check diabetes type assignment.
Collection methods:	Ask the individual the year when he/ she started to use insulin. Alternatively obtain this information from appropriate documentation, if available.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references:	Supersedes Year insulin started, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Superseded 21/09/2005 Diabetes (clinical) DSS Health, Standard 21/09/2005

Year of arrival in Australia

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—year of first arrival in Australia, date YYYY
METeOR identifier:	269929
Registration status:	Health, Standard 04/05/2005 Community services, Standard 01/03/2005
Definition:	The year a person (born outside of Australia) first arrived in Australia, from another country, with the intention of staying in Australia for one year or more.
Data Element Concept:	Person—year of first arrival in Australia

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	YYYY
Maximum character length:	4

Data element attributes

Collection and usage attributes

Collection methods:

Actual year of arrival in Australia.

Recommended question:

In what year did you/the person first arrive in Australia to live here for one year or more?

(Write in the calendar year of arrival or mark the box if here less than one year)

Calendar year of arrival

Will be here less than one year

It is anticipated that for the majority of people their response to the question will be the year of their only arrival in Australia. However, some respondents may have multiple arrivals in Australia. To deal with these cases in self-enumerated collections, an instruction such as 'Please indicate the year of first arrival only' should be included with the question.

While agencies are encouraged to use the recommended question described above, it is acknowledged that this is not always possible in practice. For example, where the data collection is a by-product of the provision of a health or community service, the information may be ascertained using different means. However, the recommended question should be used wherever practically possible.

Source and reference attributes

Origin:

The Australian Bureau of Statistics Standard for Year of Arrival in Australia. (last viewed 05/12/2006)

Reference documents:

The ABS standard for Year of arrival in Australia appears on the ABS website http://www.abs.gov.au/AUSSTATS/abs@.nsf/Latestproducts/4AD888364A44E87DCA25697E0018FE4C?opendocument select Other ABS Statistical Standards/Standards for Social, Labour and Demographic Variables/Cultural Diversity Variable.

Relational attributes

Related metadata references:

Supersedes Year of arrival in Australia, version 2, DE, NCSDD, NCSIMG, Superseded 01/03/2005.pdf (15.5 KB)

Implementation in Data Set Specifications:

Computer Assisted Telephone Interview demographic module DSS Health, Superseded 03/12/2008

Computer Assisted Telephone Interview demographic module DSS Health, Standard 03/12/2008

Conditional obligation:
Conditional on respondent being from a country that is not Australia.

Year of diagnosis of diabetes mellitus

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—diagnosis date (diabetes mellitus), YYYY
METeOR identifier:	269930
Registration status:	Health, Standard 01/03/2005
Definition:	The year a patient was first diagnosed as having diabetes
Context:	Public health, health care and clinical settings.
Data Element Concept:	Patient—diagnosis date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	YYYY
Maximum character length:	4

Supplementary values:

Value	Meaning
9999	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	Record the year that the patient was first diagnosed as having diabetes.
Collection methods:	Ask the individual the year when he/ she was diagnosed with diabetes. Alternatively obtain this information from appropriate documentation, if available.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references:	Supersedes Year of diagnosis of diabetes mellitus, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Superseded 21/09/2005 Diabetes (clinical) DSS Health, Standard 21/09/2005