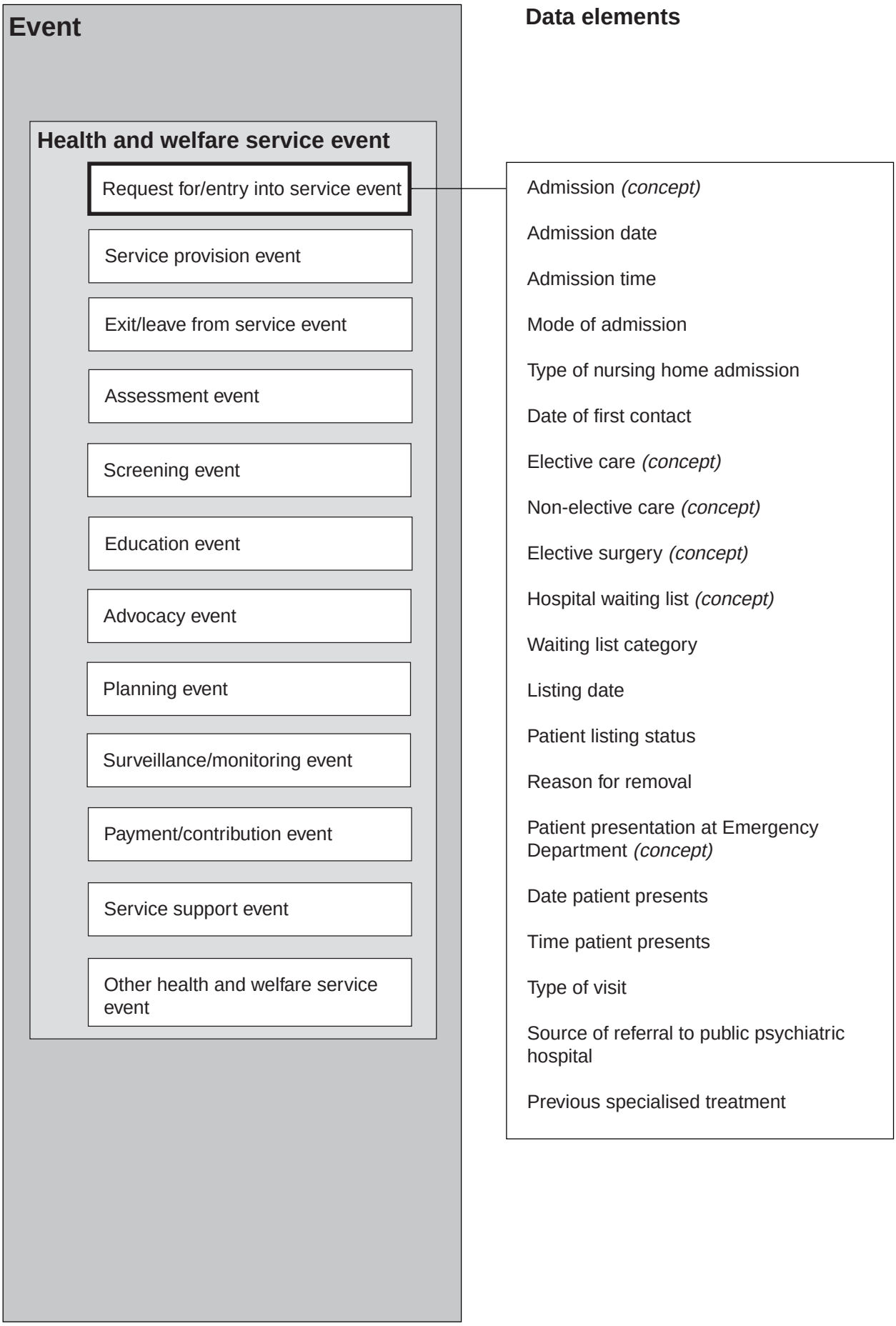
National Health Information Model entities



Admission

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000007 *Version number:* 2

Data element type: DATA ELEMENT CONCEPT

Definition: An admission is the process by which an admitted patient commences an episode of care. An admission may be formal or statistical.

Formal admission: The administrative process by which a hospital records the commencement of treatment and/or care and accommodation of a patient.

Statistical admission (on type change) is the administrative process by which a hospital records the commencement of a new episode of care for a patient within the one hospital stay.

Context: Institutional health care

Relational and representational attributes

Datatype: *Representational form:*

Field size: *Min.* *Max.* *Representational layout:*

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data: supersedes previous data element Admission, version 1

relates to the data element Type of episode of care, version 3

relates to the data element concept Admitted patient, version 2

relates to the data element Admission date, version 4

relates to the data element Admission time, version 2

relates to the data element concept Separation, version 2

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Comments: See the data element concept Admitted patient for the minimum criteria which must be met before a patient can be admitted to hospital.

Admission date

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000008 *Version number:* 4

Data element type: DATA ELEMENT

Definition: Date on which an admitted patient commences an episode of care.

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

Relational and representational attributes

Datatype: Numeric *Representational form:* DATE

Field size: *Min.* 8 *Max.* 8 *Representational layout:* DDMMYYYY

Data domain:

Guide for use:

Verification rules: Right justified and zero filled.

Admission date <= separation date.

Admission date >= date of birth

Collection methods:

Related data: is used in the calculation of Length of stay, version 1

supersedes previous data element Admission date, version 3

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

is used in the calculation of Emergency Department waiting time to admission, version 1

relates to the data element Type of visit, version 1

relates to the data element Departure status, version 1

is used in conjunction with Type of episode of care, version 3

relates to the data element concept Admitted patient, version 2

is used in the calculation of Waiting time at admission, version 1

relates to the data element concept Admission, version 2

relates to the data element Admission time, version 2

Administrative attributes

Source document:

Source organisation: National Health Data Committee

Admission date *(continued)*

National minimum data sets:

Institutional health care	from 1/07/99 to
Institutional mental health care	from 1/07/99 to
Palliative care	from 1/07/2000 to

Comments:

Admission time

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000358 *Version number:* 2

Data element type: DATA ELEMENT

Definition: Time at which an admitted patient commences an episode of care.

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

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 4 *Max.* 4 *Representational layout:* HHMM

Data domain: Expressed as hours and minutes using 24-hour clock

Guide for use:

Verification rules:

Collection methods:

Related data: relates to the data element Type of visit, version 1

supersedes previous data element Admission time, version 1

relates to the data element Departure status, version 1

relates to the data element concept Admitted patient, version 2

relates to the data element concept Admission, version 2

is used in conjunction with Admission date, version 4

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Comments:

Mode of admission

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000385 *Version number:* 4

Data element type: DATA ELEMENT

Definition: Describes the mechanism by which a person begins an episode of care.

Context: Institutional health care: to assist in analyses of intersectoral patient flow and health care planning.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1	Admitted patient transferred from another hospital
2	Statistical admission – episode type change
3	Other

Guide for use: Code 2 – use this code where a new episode of care is commenced within the same hospital stay

Code 3 – use this code for all planned admissions and unplanned admissions (except transfers into the hospital from another hospital).

Verification rules:

Collection methods:

Related data: supersedes previous data element Source of referral to acute hospital or private psychiatric hospital, version 3

supplements the data element Mode of separation, version 2

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care	from 1/07/99 to
Institutional mental health care	from 1/07/99 to
Palliative care	from 1/07/2000 to

Comments:

Type of nursing home admission

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000172 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Type of admission distinguishes respite/crisis care episodes from other nursing homes episodes.

Context: Nursing home statistics: this item will assist in analyses of demand for institutional services and planning studies.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1	Respite / crisis care (short-term admission, usually in order to give a carer respite from the provision of care
2	Other (continuing care)

Guide for use:

Verification rules:

Collection methods: This item is based on the form NH5, which has been replaced.

Related data:

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

Comments: This data element will be reviewed during 1999.

Date of first contact

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000039 *Version number:* 2

Data element type: DATA ELEMENT

Definition: The date of first contact with the community nursing service for an episode of care, between a staff member and a person or a person's family.

The definition includes:

- visits made to a person in institutional settings such as liaison visits or discharge planning visits, made in a hospital or nursing home with the intent of planning for the future delivery of service at home;

- telephone contacts when these are in lieu of a first home or hospital visit for the purpose of preliminary assessment for care at home;

- visits made to the person's home prior to admission for the purpose of assessing the suitability of the home environment for the person's care.

This applies irrespective of whether the person is present or not.

The definition excludes:

- first visits where the visit objective is not met, such as first visit made where no one is home.

Context: To enable analysis of time periods throughout a care episode, especially the pre-admission period and associated activities. This data element enables the capture of the commencement of care irrespective of the setting in which the activities took place.

Relational and representational attributes

Datatype: Numeric *Representational form:* DATE

Field size: *Min.* 8 *Max.* 8 *Representational layout:* DDMMYYYY

Data domain: Valid date

Guide for use:

Verification rules: This should occur after a previous Date of last contact of a previous care episode and prior to or on the same as Date of first delivery of service.

Collection methods: The Date of first contact can be the same as Date of first delivery of service and apply whether a person is entering care for the first time or any subsequent episode. This date should be recorded when it is the same as the first delivery of service date.

Related data: supersedes previous data element Date of first contact with the community nursing service, version 1

relates to the data element Date of last contact, version 2

Date of first contact *(continued)*

Administrative attributes

Source document:

Source organisation: Australian Council of Community Nursing Services

National minimum data sets:

Comments: This item is recommended for use in community services which are funded for liaison or discharge planning positions or provide specialist consultancy or assessment services. Further developments in community care, including casemix and coordinated care will require collection of data relating to resource expenditure across the sector.

Elective care

Admin. status: CURRENT 1/07/95

Identifying and definitional attributes

Knowledgebase ID: 000348 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

Definition: Care that, in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least twenty-four hours.

Context: Institutional health care

Relational and representational attributes

Datatype: *Representational form:*

Field size: *Min.* *Max.* *Representational layout:*

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data: relates to the data element Waiting list category, version 3

Administrative attributes

Source document:

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

National minimum data sets:

Elective surgery waiting times from 1/07/94 to

Comments:

Non-elective care

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000105 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

Definition: Care that, in the opinion of the treating clinician, is necessary and admission for which cannot be delayed for more than 24 hours.

Context: Institutional health care

Relational and representational attributes

Datatype: *Representational form:*

Field size: *Min.* *Max.* *Representational layout:*

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data:

Administrative attributes

Source document:

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

National minimum data sets:

Elective surgery waiting times from 1/07/94 to

Comments:

Elective surgery

Admin. status: CURRENT 1/07/95

Identifying and definitional attributes

Knowledgebase ID: 000046 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

Definition: Elective care where the procedures required by patients are listed in the surgical operations section of the Medicare benefits schedule book, with the exclusion of specific procedures frequently done by non-surgical clinicians.

Context: Institutional health care

Relational and representational attributes

Datatype: *Representational form:*

Field size: *Min.* *Max.* *Representational layout:*

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data: relates to the data element Waiting list category, version 3

Administrative attributes

Source document:

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

National minimum data sets:

Elective surgery waiting times from 1/07/94 to

Comments:

Hospital waiting list

Admin. status: CURRENT 1/07/95

Identifying and definitional attributes

Knowledgebase ID: 000067 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

Definition: A register which contains essential details about patients who have been assessed as needing elective hospital care.

Context: Institutional health care

Relational and representational attributes

Datatype: *Representational form:*

Field size: *Min.* *Max.* *Representational layout:*

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data: relates to the data element Patient listing status, version 3

relates to the data element Waiting list category, version 3

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

Elective surgery waiting times from 1/07/94 to

Comments:

Waiting list category

Admin. status: CURRENT 1/01/95

Identifying and definitional attributes

Knowledgebase ID: 000176 *Version number:* 3

Data element type: DATA ELEMENT

Definition: The type of elective hospital care that a patient requires.

Context: Admitted patients: hospitals maintain waiting lists which may include patients awaiting hospital care other than elective surgery – for example, dental surgery and oncology treatments. This item is necessary to distinguish patients awaiting elective surgery (code 1) from those awaiting other types of elective hospital care (code 2).

The waiting period for patients awaiting transplant or obstetric procedures is largely independent of system resource factors.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1 Elective surgery

2 Other

Guide for use: Elective surgery comprises elective care where the procedures required by patients are listed in the surgical operations section of the Medicare Benefits Schedule, with the exclusion of specific procedures frequently done by non-surgical clinicians.

Elective care is care that, in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least twenty-four hours.

Patients awaiting the following procedures should be classified as Code 2 – other:

- organ or tissue transplant procedures
- procedures associated with obstetrics (eg. elective caesarean section, cervical suture)
- cosmetic surgery, ie. 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

Waiting list category *(continued)*

Guide for use (cont'd): - 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 ICD-10-AM (International Statistical Classification of Diseases and Related Health Problems– Tenth Revision – Australian Modification (1998) National Centre for Classification in Health, Sydney) codes which are listed under Comments below. This coded list is the recommended, but optional, method for determining whether a patient is classified as requiring elective surgery or other care.

All other elective surgery should be included in waiting list Code 1 – elective surgery.

Verification rules:

Collection methods:

Related data: relates to the data element concept Elective care, version 1

supersedes previous data element Waiting list category – ICD-9-CM code, version 2

is used in conjunction with Patient listing status, version 3

is supplemented by the data element Indicator procedure, version 3

Administrative attributes

Source document: International Statistical Classification of Diseases and Related Health Problems – Tenth Revision – Australian Modification (1998) National Centre for Classification in Health, Sydney.

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

National minimum data sets:

Elective surgery waiting times from 1/07/94 to

Comments: The table of ICD-10-AM procedure codes was prepared by the National Centre for Classification in Health. Some codes were excluded from the list on the basis that they are usually performed by non-surgeon clinicians.

A more extensive and detailed listing of procedure descriptors is under development. This will replace the list in the Guide for use above, to facilitate

Waiting list category *(continued)*

Comments (cont'd): More readily the identification of the exclusions when the list of codes is not used.

ICD-10-AM CODES FOR THE EXCLUDED PROCEDURES:

Organ or tissue transplant procedures
90172-00 90204-00 90204-01 13706-08 90172-01 90324-00
90205-00 36503-00 13706-00 13706-06 13706-07 36503-01
13700-00 30375-21 90317-00 90324-00 14203-01

Procedures associated with obstetrics
36577-01 36514-00 16511-00 35500-00 35630-00 16512-00
90467-00 90469-00 90469-01 90470-00 90468-00 90468-01
90472-00 90470-02 90470-01 90470-04 90470-03 90468-02
90468-04 90478-00 90477-00 90465-03 90477-00 90466-00
90466-01 90466-02 90466-01 90471-01 90471-02 90471-03
16564-00 16564-01 90465-04 90471-05 90471-04 90468-05
90465-00 90465-01 90465-02 90471-06 90476-00 90471-00
90473-00 90474-00 90475-00 90477-00 16567-00 16520-01
16520-02 16520-03 16520-00 16603-00 16627-00 35649-00
90461-00 16600-00 16618-00 16609-00 16612-00 16615-00
16624-00 90486-00 90486-01 90486-02 90460-00 16514-00
16514-01 16606-00 90464-00 90482-00 90463-00 16621-00
16571-00 90485-00 90480-00 90480-01 90481-00 16573-00
90483-00 16567-00 90484-00 90484-02 90484-01 16570-01
16570-00

Cosmetic surgery

to be advised by NCCH

Biopsy (needle) of:

- kidney (needle only) 36561-00

- lung (needle only) 38412-00

- liver and gall bladder (needle only) 30409-00 30412-00 90319-01 30094-04

Bronchoscopy (including fibre-optic bronchoscopy)
41889-00 41892-00 41904-00 41764-02 41895-00 41764-04
41892-01 41901-00 41846-00 41898-00 41898-01 41889-01
41849-00 41764-03 41855-00

Peritoneal renal dialysis; haemodialysis
13100-06 13100-07 13100-08 13100-00

Endoscopy of:
- Biliary tract, endoscopic retrograde cholangiopancreatography (ERCP)
30484-00 30484-01 30484-02 30494-00 30452-00 30491-00 30485-01
30491-01 30485-00 30485-01 30452-01 30450-00 30452-02 90349-00

Waiting list category *(continued)*

Comments (cont'd):

Oesophagus (oesophagoscopy)
30473-03 30473-04 41822-00 30478-11 41819-00
30478-10 30478-13 41816-00 41822-00 41825-00
30478-12 41831-00 30478-12 30490-00 30479-00

small intestine (duodenoscopy)
30473-00 30473-01 32095-00 30569-00 30478-04
30478-02 30478-03 30478-00 30568-00

stomach (gastroscopy)
30473-00 30476-03 30473-01 30478-01 30478-04 30478-02
30478-03 30478-00 30473-02

large intestine (colonoscopy, proctosigmoidoscopy, sigmoidoscopy, anascopy)
32090-00 32090-01 90315-00 90308-00 32093-00 32084-00
32084-01 30479-02 32087-00 30479-01 32075-00 32075-01
32078-00 32081-00 32072-00 32072-01 32171-00

Miscellaneous cardiac procedures
38200-00 38203-00 38206-00 35309-04 38212-00 38209-00
38250-00 38250-01 38259-00 38470-00 38473-00 35309-05
90203-02 38456-07 90203-00 38456-09 38256-00 38256-01
38256-02 90202-00 90219-00 38253-00 38253-01 38253-02
38253-03 38253-04 38253-05 38253-06 38253-07 38253-08
38253-09 38253-10 38253-11 38253-12 35306-00 35306-01
35306-02 35306-04 35306-05 35309-03 35309-02 35315-00
35315-01 35324-00 38603-00 38600-00 35309-00 35309-01

Endovascular interventional procedures
35304-01 90221-00 35305-00 35310-00 35310-01 35310-03
35310-04 35310-02 35310-05 34524-00 90220-00 90214-01
90214-00 35304-00 32500-01 32500-00

Urethroscopy and associated procedures
36800-00 36800-01 37011-00 37008-01 37008-00 37315-00
37318-01 36815-01 37854-00 37318-04 35527-00

Dental procedures not attracting a Medicare rebate

to be advised by NCCH

Other diagnostic and non-surgical procedures
90347-01, Blocks [1780] to [1819], [1820] to [1939], [1940] to [2049]
and [2050] to [2199]

Listing date

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000082 *Version number:* 2

Data element type: DATA ELEMENT

Definition: The date on which a hospital accepts notification that a patient requires admission for elective hospital care.

Context: Elective surgery: this item is necessary for the calculation of 'Waiting time at admission' or 'Waiting time at a census date'.

Relational and representational attributes

Datatype: Numeric *Representational form:* DATE

Field size: *Min.* 8 *Max.* 8 *Representational layout:* DDMMYYYY

Data domain: Valid dates

Guide for use: The acceptance of the notification by the hospital is conditional upon the provision of adequate information about the patient and the appropriateness of referral of the patient to the hospital for the procedure planned.

Verification rules:

Collection methods:

Related data: Supersedes previous data element Listing date, version 1

is used in conjunction with Patient listing status, version 3

is used in conjunction with Scheduled admission date, version 2

is used in the calculation of Waiting time at a census date, version 1

is used in the calculation of Waiting time at admission, version 1

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Elective surgery waiting times from 1/07/94 to

Comments: The hospital should only accept a patient onto the waiting list when sufficient information has been provided to fulfil State/Territory, local and national reporting requirements.

Hospitals may decline to accept a referral for services which the hospital does not provide. For example, the proposed procedure may not be performed at the hospital because of a lack of a suitably qualified surgeon or necessary equipment.

Patient listing status

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000120 *Version number:* 3

Data element type: DATA ELEMENT

Definition: An indicator of the person's readiness to begin the process leading directly to being admitted to hospital for the awaited procedure. A patient may be 'ready for care' or 'not ready for care'.

Context:

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1 Ready for care

2 Not ready for care

Guide for use: Ready for care patients are those who are prepared to be admitted to hospital or to begin the process leading directly to admission. These could include investigations/procedures done on an outpatient basis, such as autologous blood collection, pre-operative diagnostic imaging or blood tests.

Not ready for care patients are those who are not in a position to be admitted to hospital. These patients are either:

- staged patients whose medical condition will not require or be amenable to surgery until some future date; for example, a patient who has had internal fixation of a fractured bone and who will require removal of the fixation device after a suitable time; or

- deferred patients who for personal reasons are not yet prepared to be admitted to hospital; for example, patients with work or other commitments which preclude their being admitted to hospital for a time.

Not ready for care patients could be termed staged and deferred waiting list patients, although currently health authorities may use different terms for the same concepts.

Staged and deferred patients should not be confused with patients whose operation is postponed for reasons other than their own unavailability; for example, surgeon unavailable, operating theatre time unavailable owing to emergency workload. These patients are still 'ready for care'. Periods when patients are not ready for care should be excluded in determining 'Waiting time at admission' and 'Waiting time at a census date'.

Verification rules:

Collection methods:

Related data: relates to the data element concept Hospital waiting list, version 1

supersedes previous data element Patient listing status, version 2

Patient listing status *(continued)*

Related data (cont'd): is used in conjunction with Waiting list category, version 3

is a qualifier of Category reassignment date, version 2

Administrative attributes

Source document:

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

National minimum data sets:

Elective surgery waiting times from 1/07/94 to

Comments: Only patients ready for care are to be included in the National Minimum Data Set – waiting times. The dates when a patient listing status changes need to be recorded. A patient's classification may change if he or she is examined by a clinician during the waiting period, i.e. undergoes clinical review. The need for clinical review varies with the patient's condition and is therefore at the discretion of the treating clinician. The waiting list information system should be able to record dates when the classification is changed (data element Category reassignment date).

At the Waiting Times Working Group meeting on 9 September 1996, it was agreed to separate data elements Patient listing status and Clinical urgency as the combination of these items had led to confusion.

Reason for removal

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000142 *Version number:* 2

Data element type: DATA ELEMENT

Definition: The reason why a patient is removed from the waiting list.

Context: Elective surgery: routine admission for the awaited procedure is only one reason why patients are removed from the waiting list. Each reason for removal provides different information. These data are necessary to augment census and throughput data. For example, after an audit the numbers of patients on a list would be expected to reduce. If an audit were undertaken immediately prior to a census the numbers on the list may appear low and not in keeping with the number of additions to the list and patients admitted from the list.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1	Admitted as an elective patient for awaited procedure in this hospital
2	Admitted as an emergency patient for awaited procedure in this hospital
3	Could not be contacted (includes patients who have died while waiting whether or not the cause of death was related to the condition requiring treatment)
4	Treated elsewhere for awaited procedure
5	Surgery not required or declined

Guide for use: Patients undergoing the awaited procedure whilst admitted for another reason are to be coded as code 1.

Code 2 identifies patients who were admitted ahead of their normal position in the queue because the condition requiring treatment deteriorated whilst waiting. Admission as an emergency patient could also be due to other causes such as inappropriate urgency rating, delays in the system, or unpredicted biological variation. Codes 3-5 provide an indication of the amount of clerical audit of the waiting lists. Code 4 gives an indication of patients treated in other hospitals for the awaited procedure. The procedure may have been performed as an emergency or as an elective procedure.

Verification rules:

Collection methods:

Related data: supersedes previous data element Reason for removal, version 1

Administrative attributes

Source document:

Reason for removal *(continued)*

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

National minimum data sets:

Elective surgery waiting times from 1/07/94 to

Comments:

Patient presentation at Emergency Department

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000349 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

Definition: The presentation of a patient at an Emergency Department occurs following the arrival of the patient at the Emergency Department and is the earliest occasion of being:

- registered clerically; or

- triaged; or

- provided with a service by a treating medical officer or nurse.

(In hospital data collection systems, the time and date of the first contact would be selected from the earliest three different recorded times.)

Context: Institutional health care

Relational and representational attributes

Datatype: *Representational form:*

Field size: *Min.* *Max.* *Representational layout:*

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data:

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

Emergency Department waiting times from 1/07/99 to

Comments: This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department Waiting Times National Minimum Data Set.

Date patient presents

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000350 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The day on which the patient presents at the Emergency Department for the delivery of a service.

Context: Institutional health care: required to identify commencement of a visit and for calculation of waiting times.

Relational and representational attributes

Datatype: Numeric *Representational form:* DATE

Field size: *Min.* 8 *Max.* 8 *Representational layout:* DDMMYYYY

Data domain: Valid dates

Guide for use:

Verification rules:

Collection methods:

Related data: relates to the data element Admission date, version 4
relates to the data element Emergency Department waiting time to service delivery, version 1
relates to the data element Emergency Department waiting time to admission, version 1
relates to the data element concept Patient presentation at Emergency Department, version 1
relates to the data element Time patient presents, version 1
relates to the data element Type of visit, version 1
relates to the data element Date of triage, version 1
relates to the data element Time of triage, version 1
relates to the data element Triage category, version 1
relates to the data element Date of service event, version 1
relates to the data element Time of service event, version 1
relates to the data element Admission time, version 1
relates to the data element Departure status, version 1

Administrative attributes

Source document:

Source organisation: National Institution Based Ambulatory Model Reference Group; National Health Data Committe

National minimum data sets:

Emergency Department waiting times from 1/07/99 to

Comments: This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department Waiting Times National Minimum Data Set.

Time patient presents

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000351 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The time at which the patient presents at the Emergency Department for the delivery of a service.

Context: Institutional health care: required to identify commencement of a visit and for calculation of waiting times.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 4 *Max.* 4 *Representational layout:* HHMM

Data domain: Expressed as hours and minutes using 24-hour clock

Guide for use: The time of patient presentation at the Emergency Department is the earliest occasion of being registered clerically or triaged.

Verification rules:

Collection methods:

Related data: relates to the data element Admission date, version 4
relates to the data element Emergency Department waiting time to service delivery, version 1
relates to the data element Emergency Department waiting time to admission, version 1
relates to the data element concept Patient presentation at Emergency Department, version 1
relates to the data element Date patient presents, version 1
relates to the data element Date of triage, version 1
relates to the data element Time of triage, version 1
relates to the data element Triage category, version 1
relates to the data element Date of service event, version 1
relates to the data element Time of service event, version 1
relates to the data element Admission time, version 1

Administrative attributes

Source document:

Source organisation: National Institution Based Ambulatory Model Reference Group; National Health Data Committe

National minimum data sets:

Emergency Department waiting times from 1/07/99 to

Comments: This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department Waiting Times National Minimum Data Set.

Type of visit

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000352 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The reason the patient presents to the Emergency Department.

Context: Institutional health care: Required for analysis of Emergency Department services.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1	Emergency presentation: Attendance for an actual or suspected condition which is sufficiently serious as 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 institution
5	Dead on arrival: A patient who is dead on arrival at presentation to the Emergency Department

Guide for use:

Verification rules:

Collection methods:

Related data: relates to the data element Admission date, version 4

relates to the data element Emergency Department waiting time to service delivery, version 1

relates to the data element Emergency Department waiting time to admission, version 1

relates to the data element concept Patient presentation at Emergency Department, version 1

relates to the data element Date patient presents, version 1

relates to the data element Time patient presents, version 1

relates to the data element Date of triage, version 1

relates to the data element Time of triage, version 1

relates to the data element Triage category, version 1

Type of visit *(continued)*

Related data (cont'd): relates to the data element Date of service event, version 1

relates to the data element Time of service event, version 1

relates to the data element Admission time, version 1

Administrative attributes

Source document:

Source organisation: National Institution Based Ambulatory Model Reference Group; National Health Data Committe

National minimum data sets:

Emergency Department waiting times from 1/07/99 to

Comments: This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department Waiting Times National Minimum Data Set.

Source of referral to public psychiatric hospital

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000150 *Version number:* 3

Data element type: DATA ELEMENT

Definition: Source from which the person was transferred/referred to the public psychiatric hospital.

Context: Institutional health care: to assist in analyses of intersectoral patient flow and health care planning.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 2 *Max.* 2 *Representational layout:* NN

Data domain:

01	Private psychiatric practice
02	Other private medical practice
03	Other public psychiatric hospital
04	Other health care establishment
05	Other private hospital
06	Law enforcement agency
07	Other agency
08	Outpatient department
09	Other
10	Unknown

Guide for use:

Verification rules:

Collection methods:

Related data: supersedes previous data element Source of referral, version 1

supplements the data element Mode of separation, version 2

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Comments: This data element is under review during 1999.

Previous specialised treatment

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000139 *Version number:* 3

Data element type: DATA ELEMENT

Definition: Whether a patient has had a previous admission or service contact for treatment in the specialty area within which treatment is now being provided.

Context:

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1	Patient has no previous admission(s) or service contact(s) for the specialised treatment now being provided
2	Patient has previous hospital admission(s) but no service contact(s) for the specialised treatment now being provided
3	Patient has previous service contact(s) but no hospital admission(s) for the specialised treatment now being provided
4	Patient has both previous hospital admission(s) and service contact(s) for the specialised treatment now being provided
5	Unknown/not stated

Guide for use: For codes 2-4 Includes patients who have been seen at any time in the past within the speciality within which the patient is currently being treated (mental health or palliative care), regardless of whether it was part of the current episode or a previous admission/service contact many years in the past. Use these codes regardless of whether the previous treatment was provided within the service in which the person is now being treated, or another equivalent specialised service (either institutional or community-based).

Admitted patients, whose only prior specialised treatment contact was the service contact that referred the patient for admission should be coded as category 1.

Verification rules:

Collection methods:

Related data: supersedes previous data element First admission for psychiatric treatment, version 2

relates to the data element concept Service contact, version 1

Administrative attributes

Source document:

Previous specialised treatment *(continued)*

Source organisation: National Health Data Committee/National Mental Health Information Strategy Committee

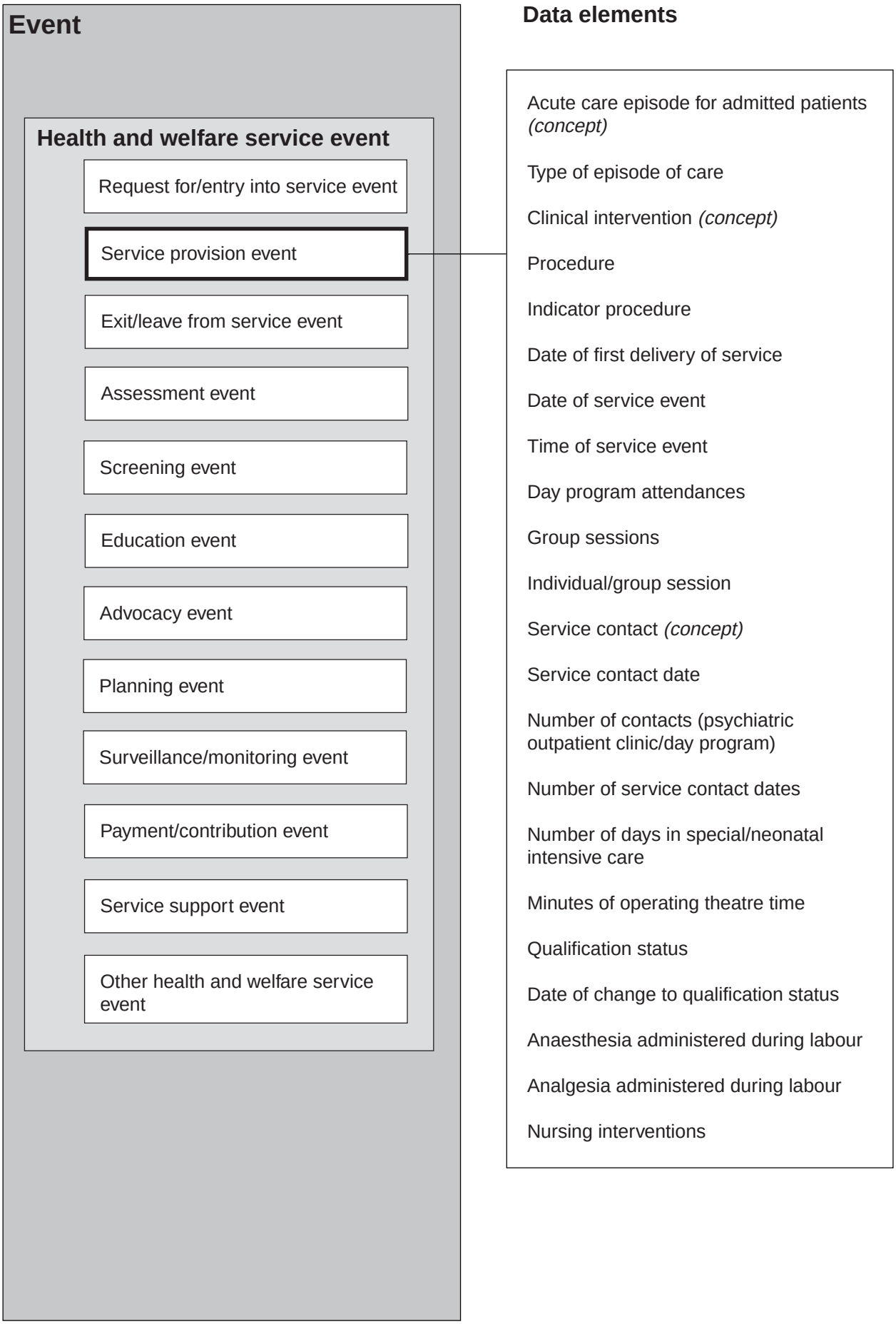
National minimum data sets:

Institutional mental health care	from 1/07/99 to
Palliative care	from 1/07/2000 to

Comments: This data item was originally developed in the context of mental health institutional care data development (originally 'Problem status' and later 'First admission for psychiatric treatment'). More recent data development work, particularly in the area of palliative care, led to the need for this data item to be re-worded in more generic terms for inclusion in other data sets.

For palliative care, the value of this data element is in its use in enabling approximate identification of the number of new palliative care patients receiving specialised treatment. The use of this data element in this way would be improved by the reporting of this data by community-based services.

National Health Information Model entities



Acute care episode for admitted patients

Admin. status: CURRENT 1/07/95

Identifying and definitional attributes

Knowledgebase ID: 000004 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

Definition: An episode of acute care for an admitted patient is one in which the principal clinical intent is to do one or more of the following:

- manage labour (obstetric);
- cure illness or provide definitive treatment of injury;
- perform surgery;
- relieve symptoms of illness or injury (excluding palliative care);
- reduce severity of illness or injury;
- protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal functions;
- perform diagnostic or therapeutic procedures.

Context: Institutional health care

Relational and representational attributes

Datatype: *Representational form:*

Field size: *Min.* *Max.* *Representational layout:*

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data: relates to the data element Type of episode of care, version 2

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Comments:

Type of episode of care

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000168 *Version number:* 3

Data element type: DATA ELEMENT

Definition: An episode of care is a phase of treatment. It is described by one of the following types of care:

- An episode of acute care for an admitted patient is one in which the principal clinical intent is one or more of the following:

- to manage labour (obstetric);

- to cure illness or provide definitive treatment of injury;

- to perform surgery;

- to relieve symptoms of illness or injury (excluding palliative care);

- to reduce severity of an illness or injury;

- to protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function; and/or

- to perform diagnostic or therapeutic procedures.

An episode of rehabilitation care occurs when a person with a disability is participating in a multidisciplinary program aimed at an improvement in functional capacity, retraining in lost skills and/or change in psychosocial adaptation.

An episode of palliative care occurs when a person's condition has progressed beyond the stage where curative treatment is effective and attainable or, where the person chooses not to pursue curative treatment. Palliation provides relief of suffering and enhancement of quality of life for such a person. Interventions such as radiotherapy, chemotherapy, and surgery are considered part of the palliative episode if they are undertaken specifically to provide symptomatic relief.

An episode of non-acute care includes care provided to persons who:

- are Nursing Home Type Patients (NHTPs), i.e. when a patient has been in hospital (public and private) for a continuous period exceeding 35 days and does not have a current acute care certificate issued under s.3B of the Health Insurance Act 1973 (Cwlth) or, alternatively, an order made under s.3A of that Act which determines that the patient is in need of acute care for a specified period;

- are not NHTPs or would normally not require hospital treatment but where there are factors in the home environment (physical, social, psychological) which make it inappropriate for the person to be discharged in the short term. This includes patients who are not eligible under current legislation to become NHTPs (compensable and ineligible patients) and have been in one or more hospitals for a continuous period of more than 35 days with a maximum break of seven days, who would otherwise be deemed to be NHTPs;

Type of episode of care *(continued)*

Definition (cont'd):

- are not NHTPs but are in receipt of respite care where the sole reason for admitting the person to hospital is that the care that is usually provided in another environment, e.g. at home, in a nursing home, by a relative or with a guardian, is unavailable in the short term;

- are treated in psychiatric units who have a stable but severe level of functional impairment and inability to function independently without extensive care and support and for whom the principal function is provision of care over an indefinite period.

A newborn episode of care is initiated when the patient is nine days old or less at the time of admission and continues until the care type changes or the patient is separated:

- those newborns who turn 10 days of age and require clinical care remain as newborn until separated;

- those newborns who turn 10 days of age, not requiring clinical care are separated and become boarders;

- newborns not admitted at birth (eg transferred from another hospital) aged less than 10 days will be admitted as a newborn;

- babies not previously admitted (eg transferred from another hospital) aged greater than 9 days are either boarders or admitted with an acute care type;

- within a newborn episode, until the baby turns 10 days of age, each day is deemed to be either an qualified or unqualified day. A newborn is qualified when it meets at least one of the following:

- is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient;

- is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the purpose of the provision of special care;

- is admitted to, or remains in hospital without its mother.

- If a newborn episode continues after the baby turns 10 days of age (requires clinical care) each day is counted as an acute day.

NB. newborn qualified days are equivalent to acute days and for practical purposes may be denoted as such.

An other episode of care is one where the principal clinical intent does not meet the criteria for any of the above.

Context: Institutional health care: the identification of different episodes of care is required in order to appropriately classify and count the care a person received whilst in hospital. The type of care received will determine the appropriate casemix classification that shall be employed to classify the episode.

Relational and representational attributes

Datatype:	Numeric	***Representational form:***	CODE
Field size:	***Min.*** 3 ***Max.*** 3	***Representational layout:***	N.N

Type of episode of care *(continued)*

Data domain:	1.0	Acute care
	2.1	Rehabilitation care delivered in a designated unit
	2.2	Rehabilitation care according to a designated program
	2.3	Rehabilitation care principal clinical intent
	3.1	Palliative care delivered in a designated unit
	3.2	Palliative care according to a designated program
	3.3	Palliative care principal clinical intent
	4.0	Non-acute care
	5.0	Newborn
	6.0	Other care

Guide for use:

An episode of care refers to the phase of treatment rather than to each individual patient day. There may be more than one episode of care within the one overnight stay period.

An episode of care begins on the date the person meets criteria defined above for a particular type of care; this may be the same as the date the person was admitted to hospital or a date during the hospital stay. An episode of care ends when the principal clinical intent of the care changes or when the patient is formally separated from the hospital.

A rehabilitation episode includes care provided:

- in a designated rehabilitation unit;

- in a designated rehabilitation program, or in a psychiatric rehabilitation program as designated by the state health authority for Medicare patients in a recognised hospital, for private patients in a public or private hospital as approved by a registered health benefits organisation; or

- under the principal clinical management of a rehabilitation physician, or in the opinion of the treating doctor the principal clinical intent of care is rehabilitation.

A palliative episode of care includes care provided:

- in a palliative care unit;

- in a designated palliative care program; or

- under the principal clinical management of a palliative care physician or in the opinion of the treating doctor the principal clinical intent of care is palliation.

Coding for rehabilitation/palliative care should be carried out in strict numerical sequence and only the first appropriate category should be coded; i.e. when a patient under the clinical management of a rehabilitation/palliative care physician is receiving care in a designated program, the episode should be coded to the option that is highest in the hierarchy (designated program).

Persons with mental illness may fall into any one of the care types (except newborn); classification depends on the principal clinical intent of the care received.

Type of episode of care *(continued)*

Guide for use (cont'd): The Nursing Home Type Patient criteria apply to all admitted patients regardless of the type of episode of care the patient is receiving. Once a patient meets these criteria they should be classified as a Nursing Home Type Patient.

Verification rules:

Collection methods:

Related data: supersedes previous data element Type of episode of care, version 2

is used in conjunction with Date of change to qualification status, version 1

is used in conjunction with Qualification status, version 1

is used in conjunction with Number of acute (qualified)/unqualified days for newborns, version 1

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care	from 1/07/89 to
Institutional mental health care	from 1/07/97 to
Palliative care	from 1/07/2000 to

Comments: Newborn episode: It should be noted that unqualified newborn days (and separations consisting entirely of unqualified newborn days are not to be counted under the Australian Health Care Agreements and that they are ineligible for health insurance benefit purposes.

During 1996 an National Health Data Committe Working Party considered the differing admission practices between States/Territories relating to qualified/unqualified babies. The major finding was that while, all States/Territories based their qualified/unqualified distinction on NHDD Version 5.0 definitions and the Commonwealth Circular HBF456, there was a significant difference in the implementation of P21 Type of episodes of care in regard to unqualified newborns. It is recommended that users of data contact individual State/Territory Health Authorities for advice on implementation of newborn episodes of care in that jurisdiction. The changes to this data element and the development of a method of capture of qualified/unqualified days will enable the implementation and reporting of a single episode of newborn care.

At its meeting in November 1996, the National Health Information Management Group requested that a single episode approach for newborn hospital stays be incorporated into the NHDD. This would facilitate differentiation between healthy and sick babies on the basis of clinical criteria as opposed to whether they were cared for in neonatal intensive care.

Clinical intervention

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000399 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

Definition: An intervention carried out to improve, maintain or assess the health of a person, in a clinical situation.

Clinical interventions include invasive and non-invasive procedures, and cognitive interventions.

Invasive:

(a) Therapeutic interventions where there is a disruption of the epithelial lining generally, but not exclusively, with an implied closure of an incision (e.g. operations such as cholecystectomy or administration of a chemotherapeutic drug through a vascular access device);

(b) Diagnostic interventions where an incision is required and/or a body cavity is entered (e.g. laparoscopy with/without biopsy, bone marrow aspiration).

Non-invasive:

Therapeutic or diagnostic interventions undertaken without disruption of an epithelial lining (e.g. lithotripsy, hyperbaric oxygenation; allied health interventions such as hydrotherapy; diagnostic interventions not requiring an incision or entry into a body part such as pelvic ultrasound, diagnostic imaging).

Cognitive:

An intervention which requires cognitive skills such as evaluating, advising, planning (e.g. dietary education, physiotherapy assessment, crisis intervention, bereavement counselling).

Context: Health services: Information about the surgical and non-surgical interventions provides the basis for analysis of health service usage, especially in relation to specialised resources, for example theatres and equipment or human resources.

Relational and representational attributes

Datatype: *Representational form:*

Field size: *Min.* *Max.* *Representational layout:*

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data:

Clinical intervention *(continued)*

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Comments: Classification and coding systems for procedures include the International Statistical Classification of Diseases and Related Health Problems – Tenth Revision – Australian Modification, 1998 (ICD-10-AM) and the International Classification of Primary Care (1987).

Procedure

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000137 *Version number:* 5

Data element type: DATA ELEMENT

Definition: A clinical intervention that:

- is surgical in nature; and/or

- carries a procedural risk; and/or

- carries an anaesthetic risk; and/or

- requires specialised training; and/or

- requires special facilities or equipment only available in an acute care setting.

Context: Institutional health care: this item gives an indication of the extent to which specialised resources, for example, human resources, theatres and equipment, are used. It also provides an estimate of the numbers of surgical operations performed and the extent to which particular procedures are used to resolve medical problems. It is used for classification of episodes of acute care for admitted patients into Australian Refined Diagnosis Related Groups.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 7 *Max.* 7 *Representational layout:* NNNNN-NN

Data domain:

Guide for use: Admitted patients: record all procedures undertaken during an episode of care in accordance with the ICD-10-AM Australian Coding Standards.

The order of codes should be determined using the following hierarchy:

- procedure performed for treatment of the principal diagnosis

- procedure performed for the treatment of an additional diagnosis

- diagnostic/exploratory procedure related to the principal diagnosis; or

- diagnostic/exploratory procedure related to an additional diagnosis for the episode of care.

The first edition of ICD-10-AM, the Australian modification of ICD-10, was published by the National Centre for Classification in Health and implemented from July 1998. The second edition will be published for use from July 2000.

New South Wales, Victoria, the Australian Capital Territory and the Northern Territory implemented ICD-10-AM from 1 July 1998. Other States will implement this classification from 1 July 1999.

Verification rules: As a minimum requirement procedure codes must be valid codes from ICD-10-AM procedure codes and validated against the nationally agreed age and sex edits. More extensive edit checking of codes may be utilised within individual hospitals and State and Territory information systems.

Procedure *(continued)*

Collection methods: Record and code all procedures undertaken during the episode of care in accordance with the ICD-10-AM Australian Coding Standards. An unlimited number of diagnosis and procedure codes should be able to be collected in hospital morbidity systems. Where this is not possible, a minimum of 20 codes should be able to be collected. Procedures are derived from and must be substantiated by clinical documentation.

Related data: supersedes previous data element Principal procedure – ICD-9-CM code, version 3

supersedes previous data element Additional procedures– ICD-9-CM code, version 3

is used in conjunction with Indicator procedure, version 3

is qualified by Principal diagnosis, version 3

is qualified by Additional diagnosis, version 4

supersedes previous data element Principal procedure – ICD-10-AM code, version 4

supersedes previous data element Additional procedures – ICD-10-AM code, version 4

Administrative attributes

Source document: International Statistical Classification of Diseases and Related Health Problems – Tenth Revision – Australian Modification (1998); National Centre for Classification in Health, Sydney.

Source organisation: National Centre for Classification in Health, National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/99 to

Comments: The National Centre for Classification in Health advises the National Health Data Committee of relevant changes to the ICD-10-AM.

Indicator procedure

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000073 *Version number:* 3

Data element type: DATA ELEMENT

Definition: An indicator procedure is a procedure which is of high volume, and is often associated with long waiting periods.

Context: Waiting list statistics for indicator procedures give a specific indication of performance in particular areas of elective care provision.

It is not always possible to code all elective surgery procedures at the time of addition to the waiting list. Reasons for this include that the surgeon may be uncertain of the exact procedure to be performed, and that the large number of procedures possible and lack of consistent nomenclature would make coding errors likely. Furthermore, the increase in workload for clerical staff may not be acceptable. However, a relatively small number of procedures account for the bulk of the elective surgery workload. Therefore, a list of common procedures with a tendency to long waiting times is useful.

Waiting time statistics by procedure are useful to patients and referring doctors. In addition, waiting time data by procedure assists in planning and resource allocation, audit and performance monitoring.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 2 *Max.* 2 *Representational layout:* NN

Data domain:

01	Cataract extraction
02	Cholecystecomy
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
16	Not applicable

Indicator procedure *(continued)*

Guide for use: These procedure terms are defined by the ICD-10-AM (1998) 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.

New South Wales, Victoria, Australian Capital Territory and Northern Territory implemented ICD-10-AM from 1 July 1998, other States will be implementing ICD-10-AM from 1 July 1999.

Verification rules: Zero filled, right justified.

Collection methods:

Related data: supersedes previous data element Indicator procedure – ICD-9-CM code, version 2

supplements the data element Waiting list category, version 3

is used in conjunction with Procedure, version 5

Administrative attributes

Source document: International Statistical Classification of Diseases and Related Health Problems – Tenth Revision – Australian Modification (1998) National Centre for Classification in Health, Sydney.

Source organisation: National Health Data Committee

National minimum data sets:

Elective surgery waiting times from 1/07/94 to

Comments: The list of indicator procedures may be reviewed from time to time. Some health authorities already code a larger number of waiting list procedures.

ICD-10-AM codes.

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],
42722-00 [201], 42734-00 [201], 42788-00 [201],
42719-00 [201], 42731-00 [201], 42719-02 [201],
42791-02 [201], 42702-11 [200], 42716-00 [202]

cholecystectomy:

30443-00 [965], 30454-01 [965], 30455-00 [965],
30445-00 [965], 30446-00 [965], 30448-00 [965],
30449-00 [965]

Indicator procedure *(continued)*

Comments (cont'd): coronary artery bypass graft:
38497-00 [672], 38497-01 [672], 39497-02 [672],
38497-03 [672], 38497-04 [673], 38497-05 [673],
38497-06 [673], 39497-07 [673], 38500-00 [674],
38503-00 [674], 38500-01 [675], 38503-01 [675],
38500-02 [676], 38503-02 [676], 38500-03 [677],
38503-03 [677], 38500-04 [678], 38503-04 [678],
90201-00 [679], 90201-01 [679], 90201-02 [679],
90201-03 [679]

cystoscopy:
36812-00 [1088], 36812-01 [1088], 36836-00 [1097]

haemorrhoidectomy:
32138-00 [949], 32132-00 [949], 32135-00 [949], 32135-01 [949]

hysterectomy:
35653-00 [1268], 35653-01 [1268],
35653-02 [1268], 35653-03 [1268],
35661-00 [1268], 35670-00 [1268],
35667-00 [1268], 35664-00 [1268],
35657-00 [1269], 35750-00 [1269],
35756-00 [1269], 35673-00 [1269],
35673-01 [1269], 35753-00 [1269],
35753-01 [1269], 35756-01 [1269],
35756-02 [1269], 35667-01 [1269],
35664-01 [1269], 90450-00 [1238],
90450-01 [1269], 90450-02 [1238]

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]

myringotomy:
41626-00 [309], 41626-01 [309], 41632-00 [309], 41632-01 [309]

prostatectomy:
37203-00 [1165], 37203-01 [1165],
37203-02 [1165], 37207-00 [1166],
37207-01 [1166], 37200-00 [1166],
37200-01 [1166], 37200-02 [1166],
37200-06 [1166], 37200-03 [1167],
37200-04 [1167], 37209-00 [1167],
37200-05 [1167], 90407-00 [1168],
36839-03 [1162], 36869-01 [1162]

Indicator procedure *(continued)*

Comments (cont'd):

septoplasty:
41671-02 [379], 41671-03 [379], 41671-00 [378]

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], 49346-00 [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],
49517-00 [1518]

varicose veins:
32508-00 [727], 32508-01 [727], 32511-00 [727],
32504-01 [728], 32505-00 [728], 32514-00 [737]

Date of first delivery of service

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000038 *Version number:* 2

Data element type: DATA ELEMENT

Definition: The date of first delivery of service to a person in a non-institutional setting.

The definition excludes:

- visits made to persons in institutional settings such as liaison visits or discharge planning visits, made in a hospital or nursing home, with the intent of planning for the future delivery of community-based services;

- first visits where there is no contact with the person, such as a first visit where no-one is at home.

- telephone, letter or other such contacts made with the person prior to the first home visit.

In situations where the first delivery of service determines that no future visit needs to be made, the Date of first Delivery of service and the Date of last delivery of service will be the same.

Context: The Date of first delivery of service is used for the analysis of time periods within a care episode and to locate that episode in time. The date relates to the first delivery of formal services within the community setting.

Relational and representational attributes

Datatype: Numeric *Representational form:* DATE

Field size: *Min.* 8 *Max.* 8 *Representational layout:* DDMMYYYY

Data domain: Valid dates

Guide for use:

Verification rules: This date may occur on the same day or prior to the Date of last delivery of service, but must never occur after that date within the current episode of care. The date may be the same as the Date of first contact.

Collection methods: As long as contact is made with the person in a non-institutional setting, the Date of first delivery of service must be recorded. Normally this will be the first home or clinic visit and is the date most often referred to in a service agency as the admission. This date applies whether a person is being admitted for the first time, or is being re-admitted for care.

Related data: supersedes previous data element Date of first community nursing visit, version 1

relates to the data element Date of first delivery of service, version 2

Administrative attributes

Source document:

Date of first delivery of service *(continued)*

Source organisation: Australian Council of Community Nursing Services

National minimum data sets:

Comments: This date marks the most standard event, which occurs at the beginning of an episode of care in community setting. It should not be confused with the Date of first contact with a community nursing service; although they could be the same, the dates for both items must be recorded. Agencies providing hospital in the Home services should develop their own method of distinguishing between the period the person remains a formal patient of the hospital, with funding to receive services at home, and the discharge of the person into the care of the community service.

Date of service event

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000356 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The day on which the delivery of a service commences. The service is defined as commencing when a medical officer (or, if no medical officer is on duty in the Emergency Department, a treating nurse) first takes responsibility for the patient's care. The commencement of assessment of the patient by the medical officer is included as taking responsibility for care.

Context: Institutional health care: Required to identify the commencement of the service and calculation of waiting times.

Relational and representational attributes

Datatype: Numeric *Representational form:* DATE

Field size: *Min.* 8 *Max.* 8 *Representational layout:* DDMMYYYY

Data domain: Valid dates

Guide for use:

Verification rules:

Collection methods:

Related data: relates to the data element Emergency Department waiting time to service delivery, version 1

relates to the data element concept Patient presentation at Emergency Department, version 1

relates to the data element Time of service event, version 1

Administrative attributes

Source document:

Source organisation: National Institution Based Ambulatory Model Reference Group; National Health Data Committe

National minimum data sets:

Emergency Department waiting times from 1/07/99 to

Comments: This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department Waiting Times National Minimum Data Set.

Time of service event

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000357 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The time at which the delivery of a service commences. The service is defined as commencing when a medical officer (or, if no medical officer is on duty in the Emergency Department, a treating nurse) first takes responsibility for the patient's care. The commencement of assessment of the patient by the medical officer is included as taking responsibility for care.

Context: Institutional health care

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 4 *Max.* 4 *Representational layout:* HHMM

Data domain: Expressed as hours and minutes using 24-hour clock

Guide for use:

Verification rules:

Collection methods:

Related data: relates to the data element Admission date, version 3

relates to the data element Emergency Department waiting time to service delivery, version 1

relates to the data element Emergency Department waiting time to admission, version 1

relates to the data element concept Patient presentation at Emergency Department, version 1

relates to the data element Date patient presents, version 1

relates to the data element Time patient presents, version 1

relates to the data element Type of visit, version 1

relates to the data element Time of triage, version 1

relates to the data element Date of service event, version 1

relates to the data element Admission time, version 1

Administrative attributes

Source document:

Source organisation: National Institution Based Ambulatory Model Reference Group; National Health Data Committe

National minimum data sets:

Emergency Department waiting times from 1/07/99 to

Comments:

Day program attendances

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000211 *Version number:* 1

Data element type: DERIVED DATA ELEMENT

Definition: A count of the number of patient/client visits to day centres. Each individual is to be counted once for each time they attend a day centre. Where an individual is referred to another section of the hospital/centre and returns to the day centre after treatment only one visit is to be recorded.

Context: Required to measure adequately non-admitted patient services in psychiatric hospitals and alcohol and drug hospitals.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 5 *Representational layout:* NNNNN

Data domain: Number of attendances

Guide for use:

Verification rules:

Collection methods:

Related data:

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

Comments: Difficulties were envisaged in using the proposed definitions of an individual or group occasion of service for clients attending psychiatric day care centres. These individuals may receive both types of services during a visit to a centre.

This data element is derived from data elements that are not currently specified in the National Health Data Dictionary, but which are recorded in various ways by hospitals and/or outpatient departments. Examples include identifiers of individual consultations/visits, diagnostic tests, etc. Further specification/development of these data elements is expected as part of the National Institution Based Ambulatory Care Modelling (NIBAM) Project.

Group sessions

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000210 *Version number:* 1

Data element type: DERIVED DATA ELEMENT

Definition: The number of groups of patients/clients receiving services. Each group is to count once, irrespective of size or the number of staff providing services.

Context: Institutional health care: the resources required to provide services to groups of patients are different from those required to provide services to an equivalent number of individuals. Hence services to groups of non-admitted patients or outreach clients should be counted separately from services to individuals.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 6 *Representational layout:* NNNNNN

Data domain: Number of groups receiving services

Guide for use:

Verification rules:

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.

Related data:

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

Institutional health care from 1/07/89 to

Comments: This data element is derived from data elements that are not currently specified in the National Health Data Dictionary, but which are recorded in various ways by hospitals and/or outpatient departments. Examples include identifiers of individual consultations/visits, diagnostic tests, etc.

Individual / group session

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000235 *Version number:* 1

Data element type: DATA ELEMENT

Definition: A group is defined as two or more patients receiving services at the same time from the same hospital staff. However, this excludes the situation where individuals all belong to the same family. In such cases the service is being provided to the family unit and as a result the session should be counted as a single occasion of service to an individual.

Context: Required to distinguish between those occasions of service on an individual patient basis and those servicing groups of patients. This distinction has resource implications.

Relational and representational attributes

Datatype: Alphanumeric *Representational form:* CODE

Field size: *Min.* 5 *Max.* 5 *Representational layout:* ANNN.N

Data domain: A12.1 Individual sessions

A12.2 Group sessions

Guide for use:

Verification rules:

Collection methods:

Related data:

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

Institutional health care from 1/07/89 to

Comments:

Service contact

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000401 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

Definition: A contact between a patient/client and an ambulatory care health unit (including outpatient and community health units) which results in a dated entry being made in the patient/client record.

Context: Identifies service delivery at the patient level for mental health services (including consultation/liaison, mobile and outreach services).

A service contact can include either face-to-face, telephone or video link service delivery modes. Service contacts would either be with a client, carer or family member or another professional or mental health worker involved in providing care and do not include contacts of an administrative nature (eg. telephone contact to schedule an appointment) except where a matter would need to be noted on a patient's record.

Service contacts may be differentiated from administrative and other types of contacts by the need to record data in the client record. However, there may be instances where notes are made in the client record that have not been prompted by a service contact with a patient/client (e.g. noting receipt of test results that require no further action). These instances would not be regarded as a service contact.

Relational and representational attributes

Datatype: *Representational form:*

Field size: *Min.* *Max.* *Representational layout:*

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data: relates to the data element Number of service contact dates, version 2

relates to the data element Service contact date, version 1

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

Comments: The proposed definition is not able to measure case complexity or level of resource usage with each service contact alone. This limitation also applies to the concept of occasions of service (in institutional health care) and hospital

Service contact *(continued)*

Comments (cont'd): separations. Some overlap with the data element Occasions of service is acknowledged by the National Health Data Committee and is subject to further work during 1999. The National Health Data Committee also acknowledges that information about group sessions or activities that do not result in a dated entry being made in each individual participant's patient/client record is not currently covered by this data element concept. The Committee will also be considering ways of capturing this information during 1999.

Service contact date

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000402 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The date of each service contact between a health service provider and patient/client.

Context: Community-based mental health care: Collection of the date of each service contact with health service providers allows a description or profile of service utilisation by a person or persons during an episode of care.

Relational and representational attributes

Datatype: Numeric *Representational form:* DATE

Field size: *Min.* 8 *Max.* 8 *Representational layout:* DDMMYYYY

Data domain: Valid date

Guide for use: Requires services to record the date of each service contact, including the same date where multiple visits are made on one day (except where the visits may be regarded as a continuation of the one service contact).

Where an individual patient/client participates in a group activity a service contact date is recorded if the person's participation in the group activity results in a dated entry being made in the patient's/client's record.

Verification rules:

Collection methods: For collection from community based (ambulatory and non-residential) agencies.

Related data: is used in the derivation of Number of service contact dates, version 2

relates to the data element concept Service contact, version 1

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

Comments: The National Health Data Committee acknowledges that information about group sessions or activities that do not result in a dated entry being made in each individual participant's patient/client record is not obtained via this data element. The Committee will be considering ways of capturing this information during 1999.

Number of contacts (psychiatric outpatient clinic/day program)

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000141 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Number of days that a patient attended a psychiatric outpatient clinic or a day program during the relevant financial year.

Context: Mental health statistics: this data element gives a measure of the level of service provided

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 3 *Representational layout:* NNN

Data domain: Count in number of days

Guide for use:

Verification rules:

Collection methods: All States and Territories where there are public psychiatric hospitals also collect date of contact, and number of contacts during the financial year can be derived from this. (Collection status for New South Wales is unknown at time of writing.)

Related data: is an alternative to Number of service contact dates, version 2

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

Community mental health care from 1/07/2000 to

Comments: In December 1998, the National Health Information Management Group decided that the new version of this data element (named Number of service contact dates) would be implemented from 1 July 2000 in the Community mental health NMDS. Until then agencies involved in the Community mental health NMDS may report either Number of contacts (psychiatric outpatient clinic/day program) or Number of service contact dates with the expectation that agencies will make their best efforts to report against the new version of this data element (Number of service contact dates) from 1 July 1999.

Number of service contact dates

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000141 *Version number:* 2

Data element type: DERIVED DATA ELEMENT

Definition: The number of dates where a service contact was recorded for the patient/client.

Context: Community-based mental health care: This data element gives a measure of the level of service provided to a patient/client.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 3 *Representational layout:* NNN

Data domain:

Guide for use: This data element is a count of service contact dates recorded on a patient or client record. Where multiple service contacts occur on the same date, the date is counted only once.

Verification rules:

Collection methods: For collection from community based (ambulatory and non-residential) agencies. Includes mental health day programs and psychiatric outpatients.

Related data: is an alternative to Number of contacts (psychiatric outpatient clinic/day program), version 1

relates to the data element concept Service contact, version 1

is derived from Service contact date, version 1

Administrative attributes

Source document:

Source organisation: National Mental Health Information Strategy Committee

National minimum data sets:

Community mental health care from 1/07/2000 to

Comments: Some overlap with the data element Occasions of service is acknowledged by the National Health Data Committee and is subject to further work during 1999. The National Health Data Committee also acknowledges that information about group sessions or activities that do not result in a dated entry being made in each individual participant's patient/client record is not obtained via this data element. The Committee will be considering ways of capturing this information during 1999.

This data element is an alternative to the data element Number of contacts (psychiatric outpatient clinic/day program). This is a transitional arrangement until 30 June 2000, whereby either data element is an acceptable standard for reporting in the Community mental health care National Minimum Data Set. From 1 July 2000, this data element (Number of service contact dates) will become the required standard for reporting this information.

Number of days in special / neonatal intensive care

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000009 *Version number:* 2

Data element type: DATA ELEMENT

Definition: Number of days spent by a neonate in a special care or neonatal intensive care nursery (in the hospital of birth).

Context: Institutional health care and perinatal statistics: an indicator of the requirements for hospital care of high-risk babies in specialised nurseries that add to costs because of extra staffing and facilities.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 3 *Representational layout:* NNN

Data domain: Number, representing the number of days spent in the special/intensive care nursery

Guide for use: The number of days is calculated from the date the baby left the special/neonatal intensive care unit minus the date the baby was admitted to the special/neonatal intensive care unit.

Verification rules:

Collection methods: This item is to be completed if baby has been treated in an intensive care unit or a special care nursery.

Special care nurseries (SCN) are staffed and equipped to provide a full range of neonatal services for the majority of complicated neonatal problems, including short-term assisted ventilation and intravenous therapy.

Neonatal intensive care nurseries (NICN) are staffed and equipped to treat critically ill newborn babies including those requiring prolonged assisted respiratory support, intravenous therapy, and alimentation and treatment of serious infections. Full supportive services are readily available throughout the hospital. These NICNs also provide consultative services to other hospitals.

Related data: supersedes previous data element Admission to special/neonatal intensive care, version 1

Administrative attributes

Source document:

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Comments:

Minutes of operating theatre time

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000094 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Total time spent by a patient in operating theatres during current episode of hospitalisation.

Context: Institutional health care

Relational and representational attributes

Datatype: Numeric *Representational form:* DATE

Field size: *Min.* 4 *Max.* 4 *Representational layout:* HHMM

Data domain:

Guide for use:

Verification rules: Right justified, zero filled.

Collection methods:

Related data:

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Comments: This item was recommended for inclusion in the National Health Data Dictionary by Hindle (1988a, 1988b) to assist with Diagnosis Related Group costing studies in Australia.

This data element has not been accepted for inclusion in the National minimum data set – institutional health care.

Qualification status

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000343 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Qualification status indicates whether the newborn day of stay is either acute (qualified) or unqualified (for all or part of a newborn episode of care).

Context: Institutional health care: To provide accurate information on care to babies to enable analysis to exclude normal babies.

Relational and representational attributes

Datatype: Alphabetic *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* A

Data domain:

A	acute (qualified) newborn day
U	unqualified newborn day

Guide for use: A newborn is qualified if it meets at least one of the following criteria:

- is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient;

- is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the purpose of the provision of special care;

- is admitted to, or remains in hospital without its mother.

A newborn is unqualified if it does not meet any of the above criteria.

Verification rules:

Collection methods:

Related data: is used in conjunction with Admitted patient, version 1

is used in conjunction with Type of episode of care, version 2

is used in the calculation of Date of change to qualification status, version 1

is used in the calculation of Number of acute (qualified)/unqualified days for newborns, version 1

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

Comments:

Date of change to qualification status

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000342 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The date, within a newborn episode of care, on which the newborn's Qualification status changes from acute (qualified) to unqualified or vice versa.

Context:

Relational and representational attributes

Datatype: Numeric *Representational form:* DATE

Field size: *Min.* 8 *Max.* 8 *Representational layout:* DDMMYYYY

Data domain: Valid date

Guide for use: Record the date or dates on which the newborn's Qualification Status changes from acute (qualified) to unqualified or vice versa.

If more than one change of qualification status occurs on a single day, the day is counted against the final qualification status.

Verification rules: Must be greater than or equal to admission date

Collection methods:

Related data: is used in conjunction with Admitted patient, version 1

is used in conjunction with Type of episode of care, version 2

is used in conjunction with Qualification status, version 1

is used in the calculation of Number of acute (qualified)/unqualified days for newborns, version 1

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

Comments:

Anaesthesia administered during labour

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000013 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Anaesthesia administered for the operative delivery of the baby (caesarean, forceps or vacuum extraction).

Context: Perinatal statistics: anaesthetic use may influence the duration of labour, may affect the health status of the baby at birth and is an indicator of obstetric intervention.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1	None
2	Local anaesthetic to perineum
3	Pudendal
4	Epidural or caudal
5	Spinal
6	General
8	Other
9	Not stated

Guide for use: If more than one agent is used, select the largest number (excluding 8 or 9) as this is how the data are tabulated.

Verification rules:

Collection methods:

Related data: is used in conjunction with Method of birth, version 1

is used in conjunction with Apgar score, version 1

Administrative attributes

Source document:

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Comments:

Analgesia administered during labour

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000014 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Agents administered to the mother by injection or inhalation to relieve pain during labour and delivery.

Context: Perinatal statistics: analgesia use may influence the duration of labour, may affect the health status of the baby at birth and is an indicator of obstetric intervention.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1	None
2	Nitrous oxide
3	Intra-muscular narcotics
4	Epidural/caudal
5	Spinal
8	Other
9	Not stated

Guide for use: If more than one agent is used, select the largest number (excluding 8 or 9) as this is how the data will be tabulated.

Verification rules:

Collection methods:

Related data: is used in conjunction with Method of birth, version 1

Administrative attributes

Source document:

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Comments:

Nursing interventions

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000112 *Version number:* 2

Data element type: DATA ELEMENT

Definition: The nursing action/s intended to relieve or alter a person's responses to actual or potential health problems.

Context: To enable analysis of the interventions within an episode of care, in relation to the outcome of this care, especially when linked with information on the diagnosis and goals. The recording of Nursing interventions is critical information for health service monitoring and planning. It is a major descriptor of the care provided throughout an episode.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1	Coordination and collaboration of care
2	Supporting informal carers
3	General nursing care
4	Technical nursing treatment or procedure
5	Counselling and emotional support
6	Teaching/education
7	Monitoring and surveillance
8	Formal case management
9	Service needs assessment only

Guide for use: For the purposes of the CNMDSA, the interventions are not necessarily linked to each nursing problem, nor are they specific tasks, but rather, broader-level intervention categories focusing on the major areas of a person's need. These summary categories subsume a range of specific actions or tasks.

The following definitions are to assist in coding:

1. COORDINATION AND COLLABORATION OF CARE occurs when there are multiple care deliverers. The goal of coordination and collaboration is the efficient, appropriate integrated delivery of care to the person. Tasks which may be involved include: liaison, advocacy, planning, referral, information and supportive discussion and/or education. Although similar in nature to formal case management this intervention is not the one formally recognised by specific funding (see Code 8).

2. SUPPORTING INFORMATION CARERS includes activities, which the nurse undertakes to assist the carer in the delivery of the carer's role. This does not include care given directly to the person. Examples of tasks involved in supporting the carer include: counselling, teaching, informing, advocacy, coordinating, and grief or bereavement support.

Nursing interventions *(continued)*

Guide for use (cont'd): 3. GENERAL NURSING CARE includes a broad range of activities, which the nurse performs to directly assist the person; in many cases, this assistance will focus on activities of daily living. This assistance will help a person whose health status, level of dependency, and/or therapeutic needs are such that nursing skills are required. Examples of tasks include: assistance with washing, grooming and maintaining hygiene, dressing, pressure area care, assistance with toileting, bladder and bowel care, assistance with mobility and therapeutic exercise, attention to physical comfort and maintaining a therapeutic environment.

4. TECHNICAL NURSING TREATMENT OR PROCEDURE refers to technical tasks and procedures for which nurses receive specific training and which require nursing knowledge of expected therapeutic effect, possible side-effects, complications and appropriate actions related to each. Some examples of technical care activities are: medication administration (including injections), dressings and other procedures, venipuncture, monitoring of dialysis, and implementation of pain management technology.

5. COUNSELLING AND EMOTIONAL SUPPORT focuses on non-physical care given to the person, which aims to address the affective, psychological and/or social needs. Examples of these include: bereavement, well being, decision-making support and values-clarification.

6. TEACHING/EDUCATION refers to providing information and/or instruction about a specific body of knowledge and/or procedure, which is relevant to the person's situation. Examples of teaching areas include: disease process, technical procedure, health maintenance, health promotion and techniques for coping with a disability.

7. MONITORING AND SURVEILLANCE refers to any action by which the nurse evaluates and monitors physical, behavioural, social and emotional responses to disease, injury, and nursing or medical interventions.

8. FORMAL CASE MANAGEMENT refers to the specific formal service, which is funded to provide case management for a person. Note that coordination and collaboration of care (Code 1) is not the same as Formal Case Management.

9. SERVICE NEEDS ASSESSMENT ONLY is assessment of the person when this is the only activity carried out and no further nursing care is given; for example, assessment for ongoing care and/or inappropriate referrals. Selection of this option means that no other intervention may be nominated. Thus, if an assessment for the Domiciliary Care Benefit is the reason for a visit, but other interventions such as, counselling and support; coordination/collaboration of care are carried out, then the Assessment only is not an appropriate code.

Verification rules: Up to eight codes may be selected. If Code 9 is selected no other nursing interventions are collected. If Code 9 is selected then code 7 in Goal of care must also be selected.

Nursing interventions *(continued)*

Collection methods: Collect on continuing basis throughout the episode in the event of data collection that occurs prior to discharge. Up to eight codes may be collected. Within a computerised information system the detailed activities can be mapped to the CNMDSA interventions enabling the option of a rich level of detail of activities or summarised information.

Related data: relates to the data element Nursing goal, version 1

supersedes previous data element Nursing interventions, version 1

relates to the data element Nursing diagnosis, version 2

Administrative attributes

Source document:

Source organisation: Australian Council of Community Nursing Services

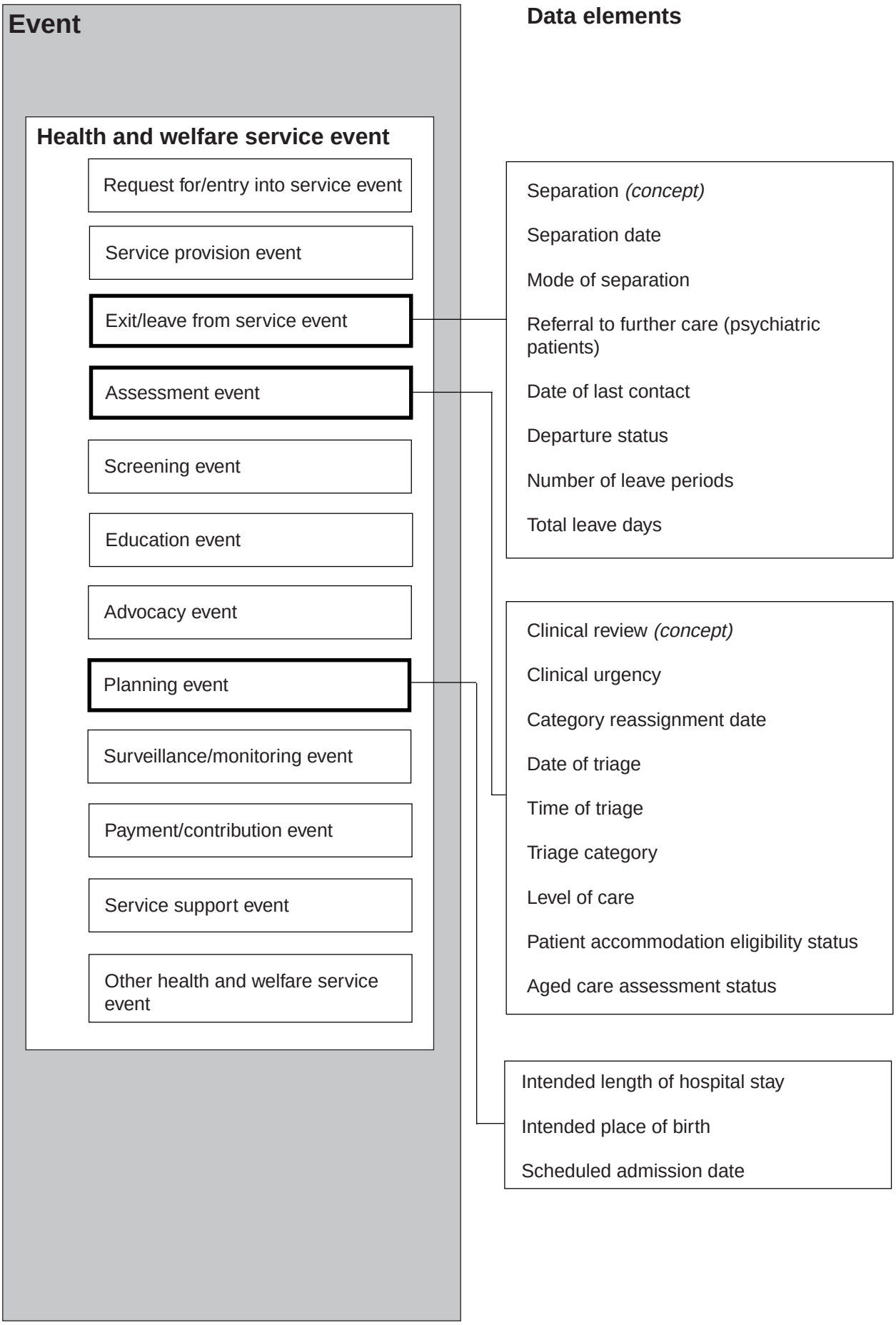
National minimum data sets:

Comments: The CNMDSA Nursing interventions are summary information overlying the detailed nursing activity usually included in an agency data collection. They are not intended as a description of nursing activities in the CNMDSA. For instance, Technical nursing treatment or Procedure is the generic term for a broad range of nursing activities such as: medication administration and wound care management.

Collection of this information at discharge carries with it the expectation that nursing records will lend themselves to this level of summarisation of the care episode. The selection of eight interventions if more are specified is a potentially subjective task unless the nursing record is structured and clear enough to enable such a selection against the reasons for admission to care, and the major focus of care delivery. Clearly, the task is easier if ongoing automated recording of interventions within an agency information system enables discharge reporting of all interventions and their frequency, over a care episode.

Those agencies providing allied health services may wish to use the Physiotherapy and Occupational Therapy Interventions developed in conjunction with the National Centre for Classification in Health in addition to the CNMDSA Nursing interventions or other more relevant code sets.

National Health Information Model entities



Separation

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000148 *Version number:* 2

Data element type: DATA ELEMENT CONCEPT

Definition: The process by which an admitted patient completes an episode of care. A separation may be formal or statistical.

Formal separation: The administrative process by which a hospital records the completion of treatment and/or care and accommodation of a patient.

Statistical separation (on type change): The administrative process by which a hospital records the completion of an episode of care for a patient within the one hospital stay.

Context: Institutional health care

Relational and representational attributes

Datatype: *Representational form:*

Field size: *Min.* *Max.* *Representational layout:*

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data: supersedes previous data element Separation, version 1

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Comments: While this concept is also applicable to non-institutional health care and welfare services, different terminology to 'separation' is often used in these other care settings.

Separation date

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000043 *Version number:* 5

Data element type: DATA ELEMENT

Definition: Date on which an admitted patient completes an episode of care.

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

Relational and representational attributes

Datatype: Numeric *Representational form:* DATE

Field size: *Min.* 8 *Max.* 8 *Representational layout:* DDMMYYYY

Data domain: Valid dates

Guide for use:

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

- be <= last day of financial year

- be >= first day of financial year

- be >= Admission date

Collection methods:

Related data: supersedes previous data element Discharge date, version 4

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care	from 1/07/99 to
Institutional mental health care	from 1/07/99 to
Palliative care	from 1/07/2000 to

Comments: There may be variations amongst jurisdictions with respect to the recording of separation date. This most often occurs for patients who are statistically separated after a period of leave (and who do not return for further hospital care). In this case, some jurisdictions may record the separation date as the date of statistical separation (and record intervening days as leave days) while other jurisdictions may retrospectively separate patients on the first day of leave. Despite the variations in recording of separation date for this group of patients, the current practices provide for the accurate recording of length of stay.

Mode of separation

Admin. status: CURRENT 1/07/93

Identifying and definitional attributes

Knowledgebase ID: 000096 *Version number:* 2

Data element type: DATA ELEMENT

Definition: Status at separation of person (discharge/transfer/death) and place to which person is released (where applicable).

Context: Institutional health care: required for outcome analyses, for analyses of intersectoral patient flows and to assist in the continuity of care and classification of episodes into Diagnosis Related Groups.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1 Discharge/transfer to an(other) acute hospital

2 Discharge/transfer to a nursing home

3 Discharge/transfer to an(other) psychiatric hospital

4 Discharge/transfer to other health care accommodation (includes mothercraft hospitals and hostels recognised by the Commonwealth Department of Health and Aged Care, unless this is the usual place of residence)

5 Statistical discharge – type change

6 Left against medical advice/discharge at own risk

7 Statistical discharge from leave

8 Died

9 Other (includes discharge to usual residence/own accommodation/ welfare institution (includes prisons, hostels and group homes providing primarily welfare services))

Guide for use: For Code 4 – In jurisdictions where mothercraft facilities are considered to be acute hospitals, patients separated to a mothercraft facility should have a mode of separation of Code 1.

Verification rules:

Collection methods:

Related data: is supplemented by the data element Source of referral to public psychiatric hospital, version 3

is supplemented by the data element Source of referral to acute hospital or private psychiatric hospital, version 3

supersedes previous data element Mode of separation, version 1

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

Mode of separation *(continued)*

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care	from 1/07/89 to
Institutional mental health care	from 1/07/97 to
Palliative care	from 1/07/2000 to

Comments: The terminology of the modes relating to statistical separation have been modified to be consistent with the changes to data element Type of episode of care and other data elements related to admissions and separations.

During 1999, the National Mental Health Information Strategy Committee is reviewing a draft data element 'Referral to further care' which will involve a review of the data element Mode of separation.

Referral to further care (psychiatric patients)

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000143 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Referral to further care by health service agencies/facilities.

Context: Mental health care: many psychiatric inpatients have continuing needs for post-discharge care. Continuity of care across the hospital-community interface is a key policy theme emerging in the various States and Territories. Inclusion of this item allows the opportunity to monitor interagency linkages and is complementary to the data element Source of referral.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1	Not referred
2	Private psychiatrist
3	Other private medical practitioner
4	Mental health / alcohol and drug in-patient facility
5	Mental health / alcohol and drug non in-patient facility
6	Acute hospital
7	Other

Guide for use:

Verification rules:

Collection methods:

Related data:

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

Comments: This data element will be reviewed during 1999.

Date of last contact

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000040 *Version number:* 2

Data element type: DATA ELEMENT

Definition: Date of the last contact between a staff member of the community service and a person in any setting.

The definition includes:

- visits made to persons in institutional settings for the purpose of handing over or otherwise completing a care episode;

- bereavement visits in any setting;

- visits made to the person's home to complete the service, including the collection of equipment.

The definition excludes:

- visits made by liaison/discharge planning staff of a community service for the purpose of assessment of need related to a subsequent episode of care.

Context: To enable analysis of time periods throughout a care episode, especially the bereavement period. This date has been included in order to capture the end of a care episode in terms of involvement of the community nursing service.

Relational and representational attributes

Datatype: Numeric *Representational form:* DATE

Field size: *Min.* 8 *Max.* 8 *Representational layout:* DDMMYYYY

Data domain: Valid dates

Guide for use: This could be the same as the date of discharge.

Verification rules: May occur after or on the same day as Date of last delivery of service

Collection methods:

Related data: supersedes previous data element Date of last community service contact with client/family, version 1

relates to the data element Date of first contact, version 2

Administrative attributes

Source document:

Source organisation: Australian Council of Community Nursing Services

National minimum data sets:

Comments: Although the data item has Recommended status only, if service agencies are committed to monitoring all resource utilisation associated with an episode of care, this post-discharge date and the corresponding pre-admission item Date of first contact, have a place within an agency information system. This is particularly true for those agencies providing discharge planning service or specialist consultancy or assessment services.

Departure status

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000359 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The status of the patient on departure from the Emergency Department.

Context: Institutional health care: Required for analysis of client care.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1	Admitted to ward or other admitted patient unit (includes patients who may have been in observation area in Emergency Department prior to admission).
2	Emergency department service event completed, departed under own care.
3	Transferred to another hospital for admission.
4	Did not wait to be attended (by medical officer).
5	Left at own risk, after medical officer assumed responsibility for the patient but before Emergency Department service event was completed.
6	Died in Emergency Department.
7	Dead on arrival, not treated in Emergency Department.

Guide for use:

Verification rules:

Collection methods:

Related data: relates to the data element Admission date, version 4

relates to the data element Emergency Department waiting time to service delivery, version 1

relates to the data element Emergency Department waiting time to admission, version 1

relates to the data element concept Patient presentation at Emergency Department, version 1

relates to the data element Date patient presents, version 1

relates to the data element Time patient presents, version 1

relates to the data element Type of visit, version 1

relates to the data element Date of triage, version 1

relates to the data element Time of triage, version 1

relates to the data element Triage category, version 1

Departure status *(continued)*

Related data (cont'd): relates to the data element Date of service event, version 1

relates to the data element Time of service event, version 1

relates to the data element Admission time, version 1

Administrative attributes

Source document:

Source organisation: National Institution Based Ambulatory Model Reference Group; National Health Data Committee

National minimum data sets:

Emergency Department waiting times from 1/07/99 to

Comments: This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department Waiting Times National Minimum Data Set.

Number of leave periods

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000107 *Version number:* 3

Data element type: DATA ELEMENT

Definition: Number of leave periods in a hospital stay (excluding one-day leave periods for admitted patients).

Leave period is a temporary absence from hospital, with medical approval for a period no greater than seven consecutive days.

Context: Institutional health care: recording of leave periods allows for the calculation of patient days excluding leave. This is important for analysis of costs per patient and for planning. The maximum limit allowed for leave affects admission and separation rates, particularly for long-stay patients who may have several leave periods.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 2 *Representational layout:* NN

Data domain: Count is number of days

Guide for use: If the period of leave is greater than seven days or of the patient fails to return from leave, the patient is discharged.

Verification rules:

Collection methods:

Related data: is used in the derivation of Length of stay, version 1

supersedes previous data element Number of leave periods, version 2

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care	from 1/07/89	to
Institutional mental health care	from 1/07/97	to

Comments: This data element was modified in July 1996 to exclude the previous differentiation between the psychiatric and other patients at the instigation of the National Mental Health Strategy Committee.

Total leave days

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000163 *Version number:* 3

Data element type: DATA ELEMENT

Definition: Sum of the length of leave (date returned from leave minus date went on leave) for all periods within the hospital stay.

Context: Institutional health care: recording of leave days allows for exclusion of these from the calculation of patient days. This is important for analysis of costs per patient and for planning. The maximum limit allowed for leave affects admission and separation rates, particularly for long-stay patients who may have several leave periods.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 3 *Representational layout:* NNN

Data domain: Count is number of days

Guide for use: A day is measured from midnight to midnight.

The following rules apply in the calculation of leave days for both overnight and same-day patients:

- The day the patient goes on leave is counted as a leave day.

- The day the patient is on leave is counted as a leave day.

- The day the patient returns from leave is counted as a patient day.

- If the patient is admitted and goes on leave on the same day, this is counted as a patient day, not a leave day.

- If the patient returns from leave and then goes on leave again on the same day, this is counted as a leave day.

- If the patient returns from leave and is separated on the same day, the day should not be counted as either a patient day or a leave day.

Verification rules: For the provision of State and Territory hospital data to Commonwealth agencies (Date of separation minus Date of admission) minus Total leave days must be >= 0 days.

Collection methods:

Related data: supersedes previous data element Total leave days, version 2

Administrative attributes

Source document:

Source organisation: National Health Data Committee

Total leave days *(continued)*

National minimum data sets:

Institutional health care	from	1/07/89	to	
Institutional mental health care	from	1/07/97	to	

Comments: It should be noted that for private patients in public and private hospitals, s.3 (12) of the Health Insurance Act 1973 (Cwlth) currently applies a different leave day count, Commonwealth Department of Human Services and Health HBF Circular 354 (31 March 1994).

This item was modified in July 1996 to exclude the previous differentiation between the psychiatric and other patients.

Clinical review

Admin. status: CURRENT 1/07/95

Identifying and definitional attributes

Knowledgebase ID: 000024 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

Definition: The examination of a patient by a clinician after the patient has been added to the waiting list. This examination may result in the patient being assigned a different urgency rating from the initial classification. The need for clinical review varies with a patient's condition and is therefore at the discretion of the treating clinician.

Context: Institutional health care

Relational and representational attributes

Datatype: *Representational form:*

Field size: *Min.* *Max.* *Representational layout:*

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data: relates to the data element Clinical urgency, version 1

relates to the data element Clinical urgency, version 2

Administrative attributes

Source document:

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

National minimum data sets:

Elective surgery waiting times from 1/07/94 to

Comments:

Clinical urgency

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000025 *Version number:* 2

Data element type: DATA ELEMENT

Definition: A clinical assessment of the urgency with which a patient requires elective hospital care.

Context: Elective surgery: categorisation of waiting list patients by clinical urgency assists hospital management and clinicians in the prioritisation of their workloads. It gives health consumers a reasonable estimate of the maximum time they should expect to wait for care.

Clinical urgency classification allows a meaningful measure of system performance to be calculated, namely the number or proportion of patients who wait for times in excess of the maximum desirable time limit for their urgency category (data element 'Overdue patient').

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1	Admission within 30 days desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency
2	Admission within 90 days desirable for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly or become an emergency
3	Admission at some time in the future acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency

Guide for use: The classification employs a system of urgency categorisation based on factors such as the degree of pain, dysfunction and disability caused by the condition and its potential to deteriorate quickly into an emergency. All patients ready for care must be assigned to one of the urgency categories, regardless of how long it is estimated they will need to wait for surgery.

Verification rules:

Collection methods:

Related data: relates to the data element concept Clinical review, version 1

supersedes previous data element Patient listing status, version 2

is used in conjunction with Patient listing status, version 3

is used in conjunction with Category reassignment date, version 2

is a qualifier of Overdue patient, version 3

Clinical urgency *(continued)*

Related data (cont'd): is a qualifier of Extended wait patient, version 1

is a qualifier of Waiting time at a census date, version 1

is a qualifier of Waiting time at admission, version 1

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Elective surgery waiting times from 1/07/94 to

Comments: A patient's classification may change if he or she undergoes clinical review during the waiting period. The need for clinical review varies with the patient's condition and is therefore at the discretion of the treating clinician. The waiting list information system should be able to record dates when the classification is changed (data element Category reassignment date).

Category reassignment date

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000391 *Version number:* 2

Data element type: DATA ELEMENT

Definition: The date on which a patient awaiting elective hospital care is assigned to a different urgency category as a result of clinical review for the awaited procedure, or is assigned to a different patient listing status category ('ready for care' or 'not ready for care').

Context: Elective surgery: this date is necessary for the calculation of Waiting time at admission and Waiting time at a census date.

Relational and representational attributes

Datatype: Numeric *Representational form:* DATE

Field size: *Min.* 8 *Max.* 8 *Representational layout:* DDMMYYYY

Data domain:

Guide for use: The date needs to be recorded each time a patient's urgency classification or listing status changes.

Verification rules:

Collection methods:

Related data: relates to the data element Clinical review, version 1

is used in conjunction with Patient listing status, version 3

is used in conjunction with Clinical urgency, version 2

supersedes previous data element Urgency reassignment date, version 1

is used in the calculation of Waiting time at a census date, version 1

is used in the calculation of Waiting time at admission, version 1

Administrative attributes

Source document:

Source organisation: Australian Institute of Health and Welfare, National Health Data Committee

National minimum data sets:

Elective surgery waiting times from 1/07/94 to

Comments:

Date of triage

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000353 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The day on which the patient is triaged.

Context: Institutional health care: Required to identify the commencement of the service and calculation of waiting times.

Relational and representational attributes

Datatype: Numeric *Representational form:* DATE

Field size: *Min.* 8 *Max.* 8 *Representational layout:* DDMMYYYY

Data domain: Valid dates

Guide for use:

Verification rules:

Collection methods:

Related data: relates to the data element Emergency Department waiting time to service delivery, version 1

relates to the data element concept Patient presentation at Emergency Department, version 1

relates to the data element Time of triage, version 1

Administrative attributes

Source document:

Source organisation: National Institution Based Ambulatory Model Reference Group; National Health Data Committee

National minimum data sets:

Emergency Department waiting times from 1/07/99 to

Comments: This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department Waiting Times National Minimum Data Set.

Time of triage

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000354 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The time at which the patient is triaged.

Context: Institutional health care: Required to identify the commencement of the service and calculation of waiting times.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 4 *Max.* 4 *Representational layout:* HHMM

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data: relates to the data element Admission date, version 4

relates to the data element Emergency Department waiting time to service delivery, version 1

relates to the data element Emergency Department waiting time to admission, version 1

relates to the data element concept Patient presentation at Emergency Department, version 1

relates to the data element Date patient presents, version 1

relates to the data element Time patient presents, version 1

relates to the data element Type of visit, version 1

relates to the data element Date of triage, version 1

relates to the data element Triage category, version 1

relates to the data element Date of service event, version 1

relates to the data element Time of service event, version 1

relates to the data element Admission time, version 1

Administrative attributes

Source document:

Source organisation: National Institution Based Ambulatory Model Reference Group; National Health Data Committee

National minimum data sets:

Emergency Department waiting times from 1/07/99 to

Comments: This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department Waiting Times National Minimum Data Set.

Triage category

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000355 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The urgency of the patient's need for medical and nursing care.

Context: Institutional healthcare: Required to provide data for analysis of Emergency Department processes.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1	Resuscitation: Immediate (within seconds)
2	Emergency: Within 10 minutes
3	Urgent: Within 30 minutes
4	Semi-urgent: Within 60 minutes
5	Non-urgent: Within 120 minutes

Guide for use:

Verification rules:

Collection methods: This triage classification is to be used in the Emergency Departments of hospitals. Patients will be triaged into one of five categories on the National Triage Scale according to the triageur's response to the question: 'This patient should wait for medical care no longer than ...?'.

The triage category is allocated by an experienced registered nurse or medical practitioner. If the triage category changes, record the more urgent category.

Related data: relates to the data element Non-admitted patient, version 1

relates to the data element Admission date, version 4

supersedes previous data element Triage category (trial), version 1

relates to the data element Emergency Department waiting time to service delivery, version 1

relates to the data element Emergency Department waiting time to admission, version 1

relates to the data element concept Patient presentation at Emergency Department, version 1

relates to the data element Date patient presents, version 1

relates to the data element Time patient presents, version 1

relates to the data element Type of visit, version 1

relates to the data element Date of triage, version 1

Triage category *(continued)*

Related data (cont'd): relates to the data element Time of triage, version 1

relates to the data element Date of service event, version 1

relates to the data element Time of service event, version 1

relates to the data element Admission time, version 1

relates to the data element Departure status, version 1

Administrative attributes

Source document: National Triage Scale, Australasian College for Emergency Medicine (ACEM)

Source organisation:

National minimum data sets:

Emergency Department waiting times from 1/07/99 to

Comments: This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department Waiting Times National Minimum Data Set.

Level of care

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000294 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The level of care needed by a patient / resident as assessed by the summation of scores on questions contained in the Resident Classification Instrument and subsequent classification into one of five major categories.

Context: Nursing homes: the level of resources and associated costs of providing care to nursing home residents depends on the levels of dependency of the residents. This field is an attempt to measure the levels of care required by individual residents in order that an overall profile of the nursing home population can be obtained. Such a profile is necessary to help explain cost variations both between nursing homes and over time.

At present there is no method of determining the underlying population demand for nursing home beds. changes on the level of care required on admission to a nursing home may also provide a useful indication of changes in demand.

This data element also provides a summary profile of dependency of resident population, as a basis for monitoring changes in resident profile as a consequence of assessment and other measures being introduced.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1	Very high need
2	High need
3	Medium need
4	Low need
5	Very low need
6	Ordinary care (non-RCI)
7	Extensive care (non-RCI)

Guide for use: For State nursing homes not using Resident Classification Instrument, the level of care as measured by resident classification into ordinary of extensive care.

Verification rules:

Collection methods: This item is based on the Resident Classification Instrument, which has been replaced.

Related data:

Administrative attributes

Source document:

Level of care *(continued)*

Source organisation: National minimum data set working parties

National minimum data sets:

Comments: This data element is subject to review during 1999.

Patient accommodation eligibility status

Admin. status: CURRENT 1/07/93

Identifying and definitional attributes

Knowledgebase ID: 000118 *Version number:* 2

Data element type: DATA ELEMENT

Definition: An eligible person means:

- a person who resides in Australia and whose stay in Australia is not subject to any limitation as to time imposed by law; but

- does not include a foreign diplomat or family (except where eligibility is expressly granted to such persons by the terms of a reciprocal health care agreement); or

- persons visiting Australia who are ordinarily resident in the United Kingdom, New Zealand, Sweden, Malta, Italy and the Netherlands are covered by reciprocal health care agreements. However, persons from Malta or Italy are covered for six months only.

Eligible persons must enrol with Medicare before benefits can be paid.

Context: Health services: to facilitate analyses of hospital utilisation and policy relating to health care financing.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1	Eligible public patient
2	Eligible private patient
3	Eligible Department of Veteran's Affairs patient
4	Eligible other patient
5	Ineligible patient

Guide for use: Eligible

Public patient:

- an eligible person who, on admission to a recognised hospital or soon after, elects to be a public patient; or

- an eligible public patient whose treatment is contracted to a private hospital.

A public patient shall be entitled to receive the care and treatment referred to in accordance with the Australian Health Care Agreements without charge.

Private patient:

- an eligible person who, on admission to a recognised hospital or soon after, elects to be a private patient treated by a medical practitioner of his or her choice; or elects to occupy a bed in a single room. Where such an election is made, the patient is responsible for meeting certain hospital charges as well as the professional charges raised by any treating medical or dental practitioner.

Patient accommodation eligibility status *(continued)*

Guide for use (cont'd): or

- an eligible person who chooses to be admitted to a private hospital. Where such a choice is made, the patient is responsible for meeting all hospital charges as well as the professional charges raised by any treating medical or dental practitioner.

Department of Veterans' Affairs patient: an eligible person whose charges for this hospital admission are met by the Department of Veterans' Affairs.

Other patient: an eligible patient who does not meet the criteria for above categories; that is, not an eligible public patient, not an eligible private patient or an eligible Department of Veterans' Affairs patient. This category includes compensable patients, patients with Defence Force personnel entitlements and common law cases.

Ineligible

A person who is not eligible under Medicare.

Verification rules:

Collection methods: It is recognised that a patient's accommodation status may change during the hospital stay, and it is therefore recommended that this item be recorded on separation from hospital.

It is recognised that ineligible patients may be treated as public or private patients, but for data set purposes at the present time this is not considered significant. Individual State and Territory collections may record this additional detail.

Related data: supersedes previous data element Patient accommodation status, version 1

is used in conjunction with Compensable status, version 2

is used in conjunction with Insurance status, version 2

is used in conjunction with Type of episode of care, version 3

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care	from	1/07/89	to
Institutional mental health care	from	1/07/97	to

Comments:

Aged care assessment status

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000017 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The assessment status of a person in terms of whether or not he or she has been assessed by a regional aged care assessment team and, if so, which one.

Context: Aged care assessment: useful variable when comparing resident population across systems.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1	Assessed by approved aged care assessment team
2	Assessed by non-approved aged care assessment team
3	Assessed by Commonwealth medical officer
4	Not assessed
5	Unknown

Guide for use:

Verification rules:

Collection methods: This item is based on the form NH5, which has been replaced.

Related data:

Administrative attributes

Source document:

Source organisation: Commonwealth Department of Health and Aged Care

National minimum data sets:

Comments: This data element is subject to review during 1999.

Intended length of hospital stay

Admin. status: CURRENT 1/07/94

Identifying and definitional attributes

Knowledgebase ID: 000076 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The intention of the responsible clinician at the time of the patient's admission to hospital, to discharge the patient either on the day of admission or a subsequent date.

Context: Institutional health care: to assist in the identification and casemix analysis of planned same-day patients, that is those patients who are admitted with the intention of discharge on the same day. This is also a key indicator for quality assurance activities.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1 Intended same-day

2 Intended overnight

Guide for use:

Verification rules:

Collection methods: The intended length of stay should be ascertained for all admitted patients at the time the patient is admitted to hospital.

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

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Comments: Information comparing the intended length of the episode of care and the actual length of the episode of care is considered useful for quality assurance and utilisation review purposes.

Intended place of birth

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000077 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The intended place of birth at the onset of labour.

Context: Perinatal statistics: mothers 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. Those mothers who are transferred to hospital after the onset of labour have increased risks of intervention and adverse outcomes.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

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

Guide for use:

Verification rules:

Collection methods:

Related data: is qualified by Actual place of birth, version 1

Administrative attributes

Source document:

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

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

Scheduled admission date

Admin. status: CURRENT 1/01/95

Identifying and definitional attributes

Knowledgebase ID: 000147 *Version number:* 2

Data element type: DATA ELEMENT

Definition: The date on which it is proposed that a patient on the waiting list will be admitted for an episode of care.

Context: This item is required for the purposes of hospital management – allocation of beds, operating theatre time and other resources.

Relational and representational attributes

Datatype: Numeric *Representational form:* DATE

Field size: *Min.* 8 *Max.* 8 *Representational layout:* DDMMYYYY

Data domain: Valid dates

Guide for use:

Verification rules:

Collection methods:

Related data: supersedes previous data element Scheduled admission date, version 1

is used in conjunction with Listing date, version 2

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Comments: If this data element were to be used to compare different hospitals or geographical locations, it would be necessary to specify when the scheduled date is to be allocated (for example, on addition to the waiting list).