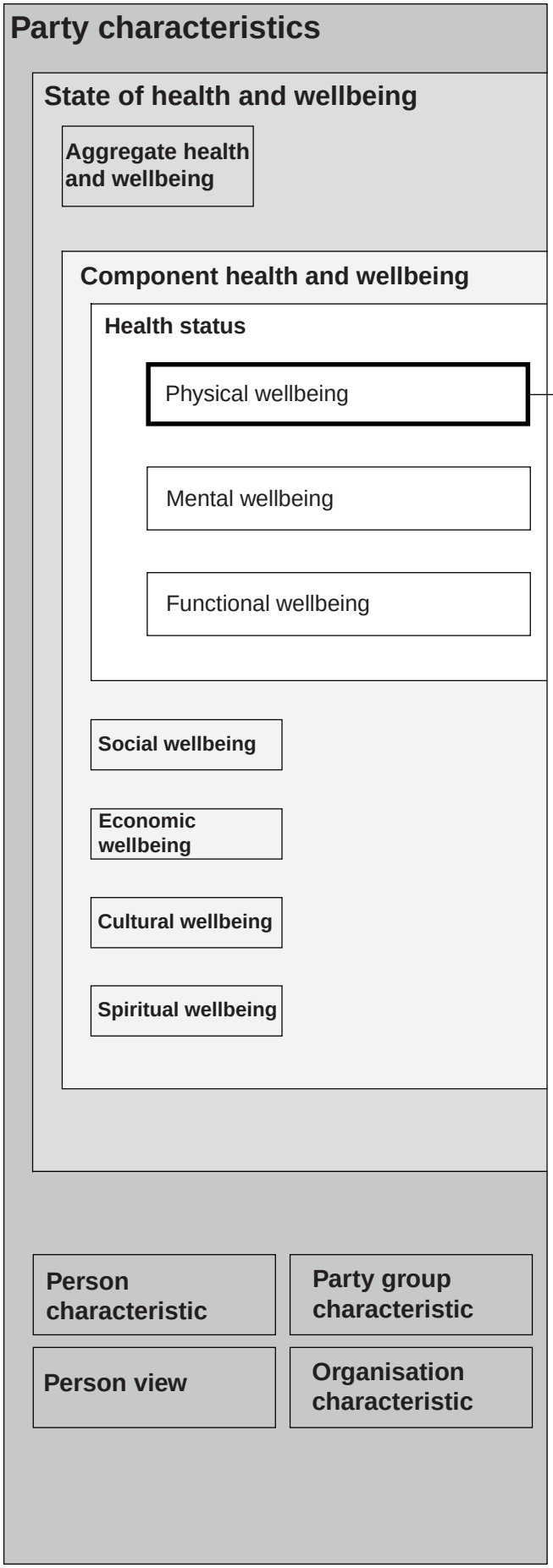
National Health Information Model entities



Data elements

- Additional diagnosis – ICD-10-AM code
- Additional diagnosis – ICD-9-CM code
- Apgar score at 1 minute
- Apgar score at 5 minutes
- Birthweight*
- Bodily location of main injury
- Complication of labour and delivery – ICD-10-AM
- Complication of labour and delivery – ICD-9-CM
- Complications of pregnancy – ICD-10-AM code
- Complications of pregnancy – ICD-9-CM code
- Congenital malformations – BPA code
- Congenital malformations – ICD-10-AM code
- Congenital malformations – ICD-9-CM code
- Date of completion of last previous pregnancy
- Diagnosis*
- Diagnosis related group
- First day of the last menstrual period
- Gestational age*
- Gestational age
- Infant weight, neonate, stillborn
- Live birth*
- Major diagnostic category
- Maternal medical conditions – ICD-10-AM code
- Maternal medical conditions – ICD-9-CM code
- Nature of main injury – non-admitted patient
- Neonatal death*
- Neonatal morbidity – ICD-10-AM code
- Neonatal morbidity – ICD-9-CM code
- Nursing diagnosis
- Outcome of last previous pregnancy
- Perinatal period*
- Perineal status
- Postpartum complication – ICD-10-AM code
- Postpartum complication – ICD-9-CM code
- Previous pregnancies
- Principal diagnosis – ICD-10-AM code
- Principal diagnosis – ICD-9-CM code
- Status of the baby
- Stillbirth (foetal death)*

*Data element concept

Additional diagnosis - ICD-10-AM code

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

NHIK identifier: 000005 ***Version number:*** 4

Data element type: DATA ELEMENT

Definition: A condition or complaint either coexisting with the principal diagnosis or arising during the episode of care or attendance at a health care facility.

Context: Institutional health care: additional diagnoses give information on factors which result in increased length of stay, more intensive treatment or the use of greater resources. They are used for casemix analyses relating to severity of illness and for correct classification of patients into Australian National Diagnosis related groups.

Relational and representational attributes

Datatype: Alphanumeric ***Representational form:*** CODE

Field size: ***Min.*** 3 ***Max.*** 6 ***Representational layout:*** ANN.NN

Data domain: ICD-10-AM - disease codes

Guide for use: Record each additional diagnosis relevant to the episode of care in accordance with the Australian Coding Standards (ICD-10-AM).

Generally, External cause, Place of occurrence and Activity codes will be included in the string of additional diagnosis codes. In some data collections these codes may also be copied into specific fields.

The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status.

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 classification is revised annually by the National Centre for Classification in Health. The version current for the collection period is required.

Verification rules:

Collection methods: An additional diagnosis should be recorded and coded upon separation for each episode of admitted patient care. The additional diagnosis is derived from and must be substantiated by clinical documentation.

Related data: supersedes previous data element Additional diagnosis - ICD-9-CM code, version 3

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

supplements the data element Principal diagnosis - ICD-10-AM code, 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.

Additional diagnosis - ICD-10-AM code *(continued)*

Source organisation: National Centre for Classification in Health (Sydney)

National minimum data sets:

Community mental health care from 1/07/98 to

Comments: Additional diagnoses are significant for the allocation of Australian National Diagnosis Related Groups. The allocation of patients to major problem or complication and co-morbidity Diagnosis Related Groups is made on the basis of the presence of certain specified Additional diagnoses. Additional diagnoses should be recorded when relevant to the patient's episode of care and not restricted by the number of fields on the morbidity form or computer screen.

This item is updated annually according to advice received from the National Centre for Classification in Health, and is consistent with the Australian Coding Standards (ICD-10-AM, 1998).

External cause codes, although not a diagnosis or condition code, should be sequenced together with the additional diagnoses codes so that meaning is given to the data for use in injury surveillance and other monitoring activities.

Additional diagnosis - ICD-9-CM code

Admin. status: SUPERSEDED 30/06/99

Identifying and definitional attributes

NHIK identifier: 000005 ***Version number:*** 3

Data element type: DATA ELEMENT

Definition: Diagnoses or conditions that affect a person's care in terms of requiring:
- therapeutic treatment;
- clinical evaluation;
- diagnostic procedure;
- extended length of hospital stay; or
- increased nursing care and/or monitoring.

Additional diagnoses include:
- co-morbid conditions, that is, co-existing conditions; and/or
- complications, that is, conditions that arose during the episode of care.

Context: Institutional health care: additional diagnoses give information on factors which result in increased length of stay, more intensive treatment or the use of greater resources. They are required for casemix analyses relating to severity of illness and for correct classification of patients into Australian National Diagnosis Related Groups.

Relational and representational attributes

Datatype: Alphanumeric ***Representational form:*** CODE

Field size: ***Min.*** 3 ***Max.*** 6 ***Representational layout:*** ANN.NN

Data domain:

Guide for use: Record all additional diagnoses made during the episode of care.

The classification is revised annually by the National Center for Health Statistics (USA) and the National Coding Centre (Australia). An Australian edition of ICD-9-CM was published by the National Coding Centre in early 1995 and implemented in July 1995.

Although this data element has been superseded by Additional diagnosis - ICD-10-AM code, Version 4, it remains an acceptable interim standard (until 30 June 1999) for use by those States and Territories that will not be implementing ICD-10-AM on 1 July 1998.

Verification rules:

Collection methods: .

Related data: supplements the data element Principal diagnosis, version 1
supplements the data element Principal diagnosis - ICD-9-CM code, version 2
supersedes previous data element Additional diagnoses, version 2
is used in the derivation of Diagnosis related group, version 1

Additional diagnosis - ICD-9-CM code *(continued)*

Administrative attributes

Source document: Australian Version of the International Classification of Diseases, 9th Revision, Clinical Modification, published by the National Centre for Classification in Health (1996) Sydney.

Source organisation: National Coding Centre (Australia)

National minimum data sets:

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

Comments: Additional diagnoses are significant for the allocation of Australian National Diagnosis Related Groups. The allocation of patients to major problem or complication and co-morbidity Diagnosis Related Groups is made on the basis of the presence of certain specified additional diagnoses. Additional diagnoses should be recorded when relevant to the patient's episode of care and not restricted by the number of fields on the morbidity form or computer screen.

This item is updated annually according to advice received from the National Centre for Classification in Health, and is consistent with the National Coding Standards.

External cause codes, although not a diagnosis or condition code, should be sequenced together with the additional diagnoses codes so that meaning is given to the data for use in injury surveillance and other monitoring activities.

Apgar score at 1 minute

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

NHIK identifier: 000344 ***Version number:*** 1

Data element type: DATA ELEMENT

Definition: Numerical score to evaluate the baby's condition at 1 minute after birth.

Context: Perinatal statistics: required to analyse pregnancy outcome, particularly after complications of pregnancy, labour and birth. The Apgar score is an indicator of the health of a baby.

Relational and representational attributes

Datatype: Numeric ***Representational form:*** CODE

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

Data domain: Apgar score (00-10), or 99 (not stated)

Guide for use: The score is based on the five characteristics of heart rate, respiratory condition, muscle tone, reflexes and colour. The maximum or best score being 10.

Verification rules:

Collection methods:

Related data: is a qualifier of Status of the baby, version 1
supersedes previous data element Apgar score, version 1

Administrative attributes

Source document:

Source organisation: National Perinatal Data Advisory Committee

National minimum data sets:

Comments:

Apgar score at 5 minutes

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

NHIK identifier: 000345 ***Version number:*** 1

Data element type: DATA ELEMENT

Definition: Numerical score to evaluate the baby's condition at 5 minutes after birth.

Context: Perinatal statistics: required to analyse pregnancy outcome, particularly after complications of pregnancy, labour and birth. The Apgar score is an indicator of the health of a baby.

Relational and representational attributes

Datatype: Numeric ***Representational form:*** CODE

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

Data domain: Apgar score (00-10), or 99 (not stated)

Guide for use: The score is based on the five characteristics of heart rate, respiratory condition, muscle tone, reflexes and colour. The maximum or best score being 10.

Verification rules:

Collection methods:

Related data: supersedes previous data element Apgar score, version 1

Administrative attributes

Source document:

Source organisation: National Perinatal Data Advisory Committee

National minimum data sets:

Comments:

Birthweight

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

NHIK identifier: 000021 ***Version number:*** 1

Data element type: DATA ELEMENT CONCEPT

Definition: The first weight of the foetus or baby obtained after birth. The World Health Organization further defines the following categories:

- Extremely low birthweight: less than 1,000 g (up to and including 999 g)
- Very low birthweight: less than 1,500 g (up to and including 1,499 g)
- Low birthweight: less than 2,500 g (up to and including 2,499 g)

Context: Perinatal

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: International Classification of Diseases and Related Health Problems, 10th Revision, WHO, 1992

Source organisation: National Perinatal Data Advisory Committee

National minimum data sets:

Perinatal collection from 1/07/97 to

Comments: The definitions of low, very low, and extremely low birthweight do not constitute mutually exclusive categories. Below the set limits they are all-inclusive and therefore overlap (i.e. low includes very low and extremely low, while very low includes extremely low).

For live births, birthweight should preferably be measured within the first hour of life before significant postnatal weight loss has occurred. While statistical tabulations include 500 g groupings for birthweight, weights should not be recorded in those groupings. The actual weight should be recorded to the degree of accuracy to which it is measured.

Bodily location of main injury

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

NHIK identifier: 000086 ***Version number:*** 1

Data element type: DATA ELEMENT

Definition: The bodily location of the injury chiefly responsible for the attendance of the person at the health care facility.

Context: Injury surveillance: the injury diagnosis is necessary for purposes including epidemiological research, casemix studies and planning. The data element Nature of main injury - non-admitted patient together with data element Bodily location of main injury indicates the diagnosis.

Relational and representational attributes

Datatype: Numeric ***Representational form:*** CODE

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

Data domain:

01	Head (excludes face [02])
02	Face (excludes eye)
03	Neck
04	Thorax
05	Abdomen
06	Lower back (includes loin)
07	Pelvis (includes perineum, anogenital area and buttocks)
08	Shoulder
09	Upper arm
10	Elbow
11	Forearm
12	Wrist
13	Hand (include fingers)
14	Hip
15	Thigh
16	Knee
17	Lower leg
18	Ankle
19	Foot (include toes)
20	Unspecified bodily location
21	Multiple injuries (involving more than one bodily location)
22	Bodily location not required

Guide for use: If the full ICD-10-AM code is used to code the injury, this item is not required (see data elements Principal diagnosis and Additional diagnosis). New South Wales, Australian Capital Territory, Victoria and the Northern Territory have implemented ICD-10-AM from 1 July 1998. Other States may continue to use ICD-9-CM until 30 June 1999.

If any code from 01 to 12 or 26 to 29 in the data element Nature of main injury has been selected, the body region affected by that injury must be specified.

Bodily location of main injury *(continued)*

Guide for use (cont'd): Select the category that best describes the location of the injury. If two or more categories are judged to be equally appropriate, select the one that comes first on the code list. A major injury, if present, should always be coded rather than a minor injury. If a major injury has been sustained (e.g. a fractured femur), along with one or more minor injuries (e.g. some small abrasions), the major injury should be coded in preference to coding 'multiple injuries'. As a general guide, an injury which, on its own, would be unlikely to have led to the attendance may be regarded as 'minor'. Bodily location of main injury code is not required with other Nature of main injury codes (code 22 may be used as a filler to indicate that a specific body region code is not required).

Verification rules:

Collection methods:

Related data: is used in conjunction with Nature of main injury - non-admitted patient, version 1

Administrative attributes

Source document:

Source organisation: AIHW National Injury Surveillance Unit and National Data Standards for Injury Surveillance Advisory Group

National minimum data sets:

Injury surveillance from 1/07/89 to

Comments: This item is related to the ICD injury and poisoning classification (in ICD-9-CM and ICD-10-AM). ICD-10-AM is the preferred national standard. However, some States and Territories may continue to use ICD-9-CM until 30 June 1999. Coding to the full ICD injury and poisoning classification (data element Principal diagnosis) is not available in most settings where basic injury surveillance is undertaken. This item, in combination with data element Nature of main injury - non-admitted patient, is a practicable alternative. Data coded to the full ICD codes can be aggregated to match this item, facilitating data comparison. Further information on the national injury surveillance program can be obtained from the National Injury Surveillance Unit, Flinders University, Adelaide.

Complication of labour and delivery - ICD-10-AM code

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

NHIK identifier: 000027 ***Version number:*** 2

Data element type: DATA ELEMENT

Definition: Medical and obstetric complications (necessitating intervention) arising after the onset of labour and before the completed delivery of the baby and placenta.

Context: Perinatal statistics: complications of labour and delivery may cause maternal morbidity and may affect the health status of the baby at birth.

Relational and representational attributes

Datatype: Alphanumeric ***Representational form:*** CODE

Field size: ***Min.*** 3 ***Max.*** 6 ***Representational layout:*** ANN.NN

Data domain: ICD-10-AM

Guide for use: There is no arbitrary limit on the number of conditions specified.

New South Wales, Australian Capital Territory, Victoria and the Northern Territory have implemented ICD-10-AM from 1 July 1998. Other States may continue to use ICD-9-CM until 30 June 1999.

Verification rules: Complications should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM

Collection methods:

Related data: is used in conjunction with Presentation at birth, version 1

is used in conjunction with Method of birth, version 1

is used in conjunction with Perineal status, version 1

is used in conjunction with Postpartum complication - ICD-10-AM code, version 2

Administrative attributes

Source document: International Statistical Classification of Diseases and Related health Problems - 10th Revision, Australian Modification (1998) National Centre for Classification in Health, Sydney.

Source organisation: National Perinatal Data Advisory Committee

National minimum data sets:

Comments:

Complication of labour and delivery - ICD-9-CM code

Admin. status: SUPERSEDED 30/06/99

Identifying and definitional attributes

NHIK identifier: 000027 ***Version number:*** 1

Data element type: DATA ELEMENT

Definition: Medical and obstetric complications (necessitating intervention) arising after the onset of labour and before the completed delivery of the baby and placenta.

Context: Perinatal statistics: complications of labour and delivery may cause maternal morbidity and may affect the health status of the baby at birth.

Relational and representational attributes

Datatype: Numeric ***Representational form:*** CODE

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

Data domain: ICD-9-CM

Guide for use: There is no arbitrary limit on the number of conditions specified.

Although this data element has been superseded by Complication of labour and delivery - ICD-10-AM code, Version 2, it remains an acceptable interim standard (until 30 June 1999) for use by those States and Territories that will not be implementing ICD-10-AM on 1 July 1998.

Verification rules:

Collection methods:

Related data: is used in conjunction with Presentation at birth, version 1

is used in conjunction with Method of birth, version 1

is used in conjunction with Perineal status, version 1

is used in conjunction with Postpartum complication - ICD-9-CM code, version 1

Administrative attributes

Source document: Australian Version of the International Classification of Diseases, 9th Revision, Clinical Modification, published by the National Centre for Classification in Health (1996) Sydney.

Source organisation: National Perinatal Data Advisory Committee

National minimum data sets:

Comments:

Complications of pregnancy - ICD-10-AM code

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

NHIK identifier: 000028 ***Version number:*** 2

Data element type: DATA ELEMENT

Definition: Complications arising up to the period immediately preceding delivery that are directly attributable to the pregnancy and may have significantly affected care during the current pregnancy and/or pregnancy outcome.

Context: Perinatal statistics: complications often influence the course and outcome of pregnancy, possibly resulting in hospital admissions and/or adverse effects on the foetus and perinatal morbidity.

Relational and representational attributes

Datatype: Alphanumeric ***Representational form:*** CODE

Field size: ***Min.*** 3 ***Max.*** 6 ***Representational layout:*** NNN.NN

Data domain: ICD-10-AM - disease codes

Guide for use: Examples of these conditions include threatened abortion, antepartum haemorrhage, pregnancy-induced hypertension and gestational diabetes. There is no arbitrary limit on the number of complications specified.

New South Wales, Australian Capital Territory, Victoria and the Northern Territory have implemented ICD-10-AM from 1 July 1998. Other States may continue to use ICD-9-CM until 30 June 1999.

Verification rules: Complications should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM

Collection methods:

Related data: is used in conjunction with Maternal medical conditions - ICD-9-CM code, version 1

supersedes previous data element Complications of pregnancy - ICD-9-CM code, version 1

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 Perinatal Data Advisory Committee

National minimum data sets:

Comments:

Complications of pregnancy - ICD-9-CM code

Admin. status: SUPERSEDED 30/06/99

Identifying and definitional attributes

NHIK identifier: 000028 ***Version number:*** 1

Data element type: DATA ELEMENT

Definition: Complications arising up to the period immediately preceding delivery that are directly attributable to the pregnancy and may have significantly affected care during the current pregnancy and/or pregnancy outcome.

Context: Perinatal statistics: complications often influence the course and outcome of pregnancy, possibly resulting in hospital admissions and/or adverse effects on the foetus and perinatal morbidity.

Relational and representational attributes

Datatype: Alphanumeric ***Representational form:*** CODE

Field size: ***Min.*** 5 ***Max.*** 6 ***Representational layout:*** NNN.NN

Data domain: ICD-9-CM

Guide for use: Examples of these conditions include threatened abortion, antepartum haemorrhage, pregnancy-induced hypertension and gestational diabetes. There is no arbitrary limit on the number of complications specified.

Although this data element has been superseded by Complications of pregnancy - ICD-10-AM code, Version 2, it remains an acceptable interim standard (until 30 June 1999) for use by those States and Territories that will not be implementing ICD-10-AM on 1 July 1998.

Verification rules:

Collection methods:

Related data: is used in conjunction with Maternal medical conditions - ICD-9-CM code, version 1

Administrative attributes

Source document: Australian Version of the International Classification of Diseases, 9th Revision, Clinical Modification, published by the National Centre for Classification in Health (1996) Sydney.

Source organisation: National Perinatal Data Advisory Committee

National minimum data sets:

Comments: .

Congenital malformations - BPA code

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

NHIK identifier: 000029 ***Version number:*** 1

Data element type: DATA ELEMENT

Definition: Structural abnormalities (including deformations) that are present at birth and diagnosed prior to separation from care.

Context: Perinatal statistics: required to monitor trends in the reported incidence of congenital malformations, to detect new drug and environmental teratogens, to analyse possible causes in epidemiological studies, and to determine survival rates and the utilisation of paediatric services.

Relational and representational attributes

Datatype: Alphanumeric ***Representational form:*** CODE

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

Data domain: British Paediatric Association (BPA) Classification of Diseases (1979)

Guide for use: Coding to the disease classification of ICD-9-CM is the preferred method of coding admitted patients. For perinatal data collection, the use of BPA is preferred as this is more detailed (see Congenital malformations - perinatal statistics).

Verification rules:

Collection methods:

Related data: is used in conjunction with Neonatal morbidity - ICD-9-CM code, version 1

Administrative attributes

Source document: British Paediatric Association Classification of Diseases (1979)

Source organisation: National Perinatal Data Advisory Committee

National minimum data sets:

Comments: There is no arbitrary limit on the number of conditions specified. Most perinatal data groups and birth defects registers in the States and Territories have used the 5-digit British Paediatric Association (BPA) Classification of Diseases to code congenital malformations since the early 1980s. The use of the classification is to be reviewed with the introduction of ICD-10.

Congenital malformations - ICD-10-AM code

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

NHIK identifier: 000030 ***Version number:*** 2

Data element type: DATA ELEMENT

Definition: Structural abnormalities (including deformations) that are present at birth and diagnosed prior to separation from care.

Context: Institutional health care: required to monitor trends in the reported incidence of congenital malformations, to detect new drug and environmental teratogens, to analyse possible causes in epidemiological studies, and to determine survival rates and the utilisation of paediatric services.

Relational and representational attributes

Datatype: Alphanumeric ***Representational form:*** CODE

Field size: ***Min.*** 3 ***Max.*** 6 ***Representational layout:*** ANN.NN

Data domain: ICD-10-AM

Guide for use: Coding to the disease classification of ICD-10-AM is the preferred method of coding admitted patients. However, for the perinatal data collection, the use of BPA is preferred as this is more detailed (see 'Congenital malformations - BPA classification').

New South Wales, Australian Capital Territory, Victoria and the Northern Territory have implemented ICD-10-AM from 1 July 1998. Other States may continue to use ICD-9-CM until 30 June 1999.

Verification rules:

Collection methods:

Related data: is used in conjunction with Neonatal morbidity - ICD-10-AM code, version 2

Administrative attributes

Source document: International Statistical Classification of Diseases and Related health Problems - 10th Revision, Australian Modification (1998) National Centre for Classification in Health, Sydney.

Source organisation: National Perinatal Data Advisory Committee

National minimum data sets:

Comments:

Congenital malformations - ICD-9-CM code

Admin. status: SUPERSEDED 30/06/99

Identifying and definitional attributes

NHIK identifier: 000030 ***Version number:*** 1

Data element type: DATA ELEMENT

Definition: Structural abnormalities (including deformations) that are present at birth and diagnosed prior to separation from care.

Context: Institutional health care: required to monitor trends in the reported incidence of congenital malformations, to detect new drug and environmental teratogens, to analyse possible causes in epidemiological studies, and to determine survival rates and the utilisation of paediatric services.

Relational and representational attributes

Datatype: Alphanumeric ***Representational form:*** CODE

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

Data domain: ICD-9-CM

Guide for use: Coding to the disease classification of ICD-9-CM is the preferred method of coding admitted patients. However, for the perinatal data collection, the use of BPA is preferred as this is more detailed.(see 'Congenital malformations - BPA classification').

Although this data element has been superseded by Congenital malformations - ICD-10-AM code, Version 2, it remains an acceptable interim standard (until 30 June 1999) for use by those States and Territories that will not be implementing ICD-10-AM on 1 July 1998.

Verification rules:

Collection methods:

Related data: is used in conjunction with Neonatal morbidity - ICD-9-CM code, version 1

Administrative attributes

Source document: Australian Version of the International Classification of Diseases, 9th Revision, Clinical Modification, published by the National Centre for Classification in Health (1996) Sydney.

Source organisation: National Perinatal Data Advisory Committee

National minimum data sets:

Comments:

Date of completion of last previous pregnancy

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

NHIK identifier: 000037 ***Version number:*** 1

Data element type: DATA ELEMENT

Definition: Date on which the pregnancy preceding the current pregnancy was completed.

Context: Perinatal statistics: interval between pregnancies may be an important risk factor for the outcome of the current pregnancy, especially for preterm birth and low birthweight.

Relational and representational attributes

Datatype: Numeric ***Representational form:*** DATE

Field size: ***Min.*** 6 ***Max.*** 8 ***Representational layout:*** DDMMYYYY

Data domain: Valid dates

Guide for use: Estimate DD, if first day is unknown.

Verification rules:

Collection methods:

Related data: is a qualifier of Previous pregnancies, version 1
is qualified by Outcome of last previous pregnancy, version 1

Administrative attributes

Source document:

Source organisation: National Perinatal Data Advisory Committee

National minimum data sets:

Comments: This data item is recommended by the World Health Organization. It is currently collected in some States and Territories.

Diagnosis

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

NHIK identifier: 000398 ***Version number:*** 1

Data element type: DATA ELEMENT CONCEPT

Definition: A diagnosis is the decision reached, after assessment, of the nature and identity of the disease or condition of a patient.

Context: Health services: Diagnostic information provides the basis for analysis of health service usage, epidemiological studies and monitoring of specific disease entities.

Relational and representational attributes

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 Complications of pregnancy - ICD-10-AM code, version 2

relates to the data element Maternal medical conditions - ICD-10-AM code, version 2

relates to the data element External cause - admitted patient - ICD-10-AM code, version 4

relates to the data element Principal diagnosis - ICD-10-AM code, version 3

relates to the data element Complication of labour and delivery - ICD-10-AM code, version 2

relates to the data element Postpartum complication - ICD-10-AM code, version 2

relates to the data element Neonatal morbidity - ICD-10-AM code, version 2

relates to the data element Congenital malformations - ICD-10-AM code, version 2

relates to the data element Additional diagnosis - ICD-10-AM code, version 4

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Comments: Classification systems which enable the allocation of a code to the diagnostic information:

Diagnosis *(continued)*

Comments (cont'd): International Statistical Classification of Diseases and Related Health Problems - Tenth Revision - Australian Modification (1998) (ICD-10-AM)

British Paediatric Association Classification of Diseases (1979)

North America Nursing Diagnosis Association (NANDA)

International Classification of Primary Care (1987)

International Classification of Impairments, Disabilities and Handicaps (1980),

International Classification of Impairments, Disabilities and HandicapsBeta/1 draft revised classification (1997)

Diagnosis related group

Admin. status: CURRENT 1/07/93

Identifying and definitional attributes

NHIK identifier: 000042 ***Version number:*** 1

Data element type: DATA ELEMENT

Definition: A patient classification scheme which provides a means of relating the number and types of patients treated in a hospital to the resources required by the hospital (AN-DRGs, 3M).

Context: Institutional health care: the development of Australian National Diagnosis Related Groups has created a descriptive framework for studying hospitalisation. Diagnosis Related Groups provide a summary of the varied reasons for hospitalisation and the complexity of cases a hospital treats. Moreover, as a framework for describing the products of a hospital (that is, patients receiving services), they allow meaningful comparisons of hospitals' efficiency and effectiveness under alternative systems of health care provision.

Relational and representational attributes

Datatype: Numeric ***Representational form:*** CODE

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

Data domain: Australian National Diagnosis Related Groups, 3M Australia Pty Ltd, Commonwealth of Australia. Version effective from 1 July each year.

Guide for use:

Verification rules:

Collection methods:

Related data: is derived from Sex, version 2
is derived from Date of birth, version 2
is derived from Admission date, version 3
is derived from Mode of separation, version 2
is derived from Principal diagnosis - ICD-9-CM code, version 2
is derived from Additional diagnosis - ICD-9-CM code, version 3
is derived from Principal procedure - ICD-9-CM code, version 3
is derived from Additional procedures - ICD-9-CM code, version 3
is derived from Intended length of hospital stay, version 1
is derived from Discharge date, version 4
is derived from Infant weight, neonate, stillborn, version 3

Administrative attributes

Source document:

Source organisation: National Health Data Committee, National Coding Centre

Diagnosis related group *(continued)*

National minimum data sets:

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

Comments:

The Diagnosis Related Groups system was developed by Yale University researchers in the USA as an aid to utilisation review. It is a classification system for acute hospital inpatients based upon diagnosis and procedures (Fetter et al. 1980).

The Commonwealth Department of Human Services and Health contracted with 3M Australia in 1991 to produce the Australian National Diagnosis Related Groups. The first version was available in July 1992.

The Australian National Diagnosis Related Group is derived from ICD-9-CM disease classification. Each new revision of the ICD-9-CM classification will be incorporated into the Australian National Diagnosis Related Group definition. Data elements required to generate Australian National Diagnosis Related Groups are described in related data elements.

Due to the modifications in the Diagnosis Related Group logic for the Australian National Diagnosis Related Groups, it is necessary to generate the Major Diagnostic Category to accompany each Diagnosis Related Group. The construction of the pre-Major Diagnostic Category logic means Diagnosis Related Groups are no longer unique. Certain pre-Major Diagnostic Category Diagnosis Related Groups may occur in any of the 23 Major Diagnostic Categories; for example, liver transplant DRG 005 may occur in any of the Major Diagnostic Categories according to the principal diagnosis. AN-DRGs 950-954 (excluding MDC 952 in most cases) also require the allocation of a Major Diagnostic Category according to the principal diagnosis (3M, Commonwealth 1992). The Major Diagnostic Category is defined in the data element of that name.

AN-DRG V4.1 is being developed and will be available for implementation in November 1998.

First day of the last menstrual period

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

NHIK identifier: 000056 ***Version number:*** 1

Data element type: DATA ELEMENT

Definition: Date of the first day of the mother's last menstrual period (LMP).

Context: Perinatal statistics: the first day of the LMP is required to estimate gestational age, which is a key outcome of pregnancy and an important risk factor for neonatal outcomes. Although the date of the LMP may not be known, or may sometimes be erroneous, estimation of gestational age based on clinical assessment may also be inaccurate. Both methods of assessing gestational age are required for analysis of outcomes.

Relational and representational attributes

Datatype: Numeric ***Representational form:*** DATE

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

Data domain: Valid dates or 99999999 if first day is unknown

Guide for use: If the first day is unknown, it is unnecessary to record the month and year (i.e. record 99999999).

Verification rules:

Collection methods:

Related data: is used in the calculation of Gestational age, version 1

Administrative attributes

Source document:

Source organisation: National Perinatal Data Advisory Committee

National minimum data sets:

Perinatal collection from 1/07/97 to

Comments:

Gestational age

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

NHIK identifier: 000059 ***Version number:*** 1

Data element type: DATA ELEMENT CONCEPT

Definition: The duration of gestation is measured from the first day of the last normal menstrual period. Gestational age is expressed in completed days or completed weeks (e.g. events occurring 280 to 286 completed days after the onset of the last normal menstrual period are considered to have occurred at 40 weeks of gestation).

WHO identifies the following categories:

Pre-term: less than 37 completed weeks (less than 259 days) of gestation

Term: from 37 completed weeks to less than 42 completed weeks (259 to 293 days) of gestation

Post-term: 42 completed weeks or more (294 days or more) of gestation.

Context: Perinatal

Relational and representational attributes

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 Gestational age, version 1

Administrative attributes

Source document:

Source organisation: National Perinatal Data Advisory Committee

National minimum data sets:

Perinatal collection from 1/07/97 to

Comments: Gestational age is frequently a source of confusion when calculations are based on menstrual dates. For the purposes of calculation of gestational age from the date of the first day of the last normal menstrual period and the date of delivery, it should be borne in mind that the first day is day zero and not day one.

Gestational age

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

NHIK identifier: 000060 ***Version number:*** 1

Data element type: DATA ELEMENT

Definition: The estimated gestational age of the baby in completed weeks as determined by clinical assessment.

Context: Perinatal statistics: the first day of the LMP is required to estimate gestational age, which is a key outcome of pregnancy and an important risk factor for neonatal outcomes. Although the date of the LMP may not be known, or may sometimes be erroneous, estimation of gestational age based on clinical assessment may also be inaccurate. Both methods of assessing gestational age are required for analysis of outcomes.

Relational and representational attributes

Datatype: Numeric ***Representational form:*** QUANTITATIVE VALUE

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

Data domain: Number representing the number of completed weeks, or 99 for not stated / unknown.

Guide for use: This is derived from clinical assessment when accurate information on the date of the last menstrual period (LMP) is not available for this pregnancy.

Verification rules:

Collection methods:

Related data: relates to the data element concept Gestational age, version 1
is calculated using First day of the last menstrual period, version 1

Administrative attributes

Source document: International Classification of Diseases and Related Health Problems, 10 Revision, WHO, 1992

Source organisation: National Perinatal Data Advisory Committee

National minimum data sets:

Perinatal collection from 1/07/97 to

Comments:

Infant weight, neonate, stillborn

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

NHIK identifier: 000010 ***Version number:*** 3

Data element type: DATA ELEMENT

Definition: The first weight of the live born or stillborn baby obtained after birth, or the weight of the neonate or infant on the date admitted if this is different from the date of birth.

Context: Weight is an important indicator of pregnancy outcome, is a major risk factor for neonatal morbidity and mortality and is required to analyse perinatal services for high-risk infants.

This item is required to generate Australian National Diagnosis Related Groups.

Relational and representational attributes

Datatype: Numeric ***Representational form:*** QUANTITATIVE VALUE

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

Data domain: 4-digit field representing the weight in grams

Guide for use: The weight is measured to the nearest five grams and obtained within one hour of birth for liveborn.

In perinatal collections the birthweight is to be provided for liveborn and stillborn babies.

Weight on the date the infant is admitted should be recorded if the weight is less than or equal to 9000g and age is less than 365 days.

Verification rules: For the provision of State and Territory hospital data to Commonwealth agencies this field must be consistent with diagnoses and procedure codes for valid grouping.

Collection methods:

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
Perinatal collection	from 1/07/97	to

Comments: This item has been modified to include the recording of birth weight for the perinatal statistics collection and the requirement of AN-DRG version 3.1, which will treat all neonates less than 28 days old, infants with a weight on the date admitted of less than 2,500 grams, and patients with a specific neonatal principal diagnosis as neonates for grouping purposes. The assumption in the

Infant weight, neonate, stillborn *(continued)*

Comments (cont'd): grouper logic is that, if the weight on the date admitted is blank, the infant's weight is greater than 2,499 grams.

At the National Health Information Management Group meeting held on 24 November 1994, this definition was endorsed for inclusion in the National Health Data Dictionary. It was further agreed that infant weight will only be collected when an infant weighs less than 2,500 grams. An understanding of the clinical value of this data item is required before collection of weight for all infants can be agreed.

Live birth

Admin. status: CURRENT 1/07/94

Identifying and definitional attributes

NHIK identifier: 000083 ***Version number:*** 1

Data element type: DATA ELEMENT CONCEPT

Definition: A live birth is defined by the World Health Organization to be the complete expulsion or extraction from the mother of a baby, irrespective of the duration of the pregnancy which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of the voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born.

Context: Perinatal

Relational and representational attributes

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 Status of the baby, version 1

Administrative attributes

Source document: International Classification of Diseases and Related Health Problems, 10th Revision, Vol 1, WHO 1992

Source organisation: National Health Data Committee
National Perinatal Data Advisory Committee

National minimum data sets:

Institutional health care	from 1/07/89	to
Perinatal collection	from 1/07/97	to

Comments:

Major diagnostic category

Admin. status: CURRENT 1/07/93

Identifying and definitional attributes

NHIK identifier: 000088 ***Version number:*** 1

Data element type: DATA ELEMENT

Definition: Major Diagnostic Categories are 23 mutually exclusive categories into which all possible principal diagnoses fall. The diagnoses in each category correspond to a single body system or aetiology, broadly reflecting the speciality providing care.

Each category is partitioned according to whether or not a surgical procedure was performed. This preliminary partitioning into Major Diagnostic Categories occurs before a Diagnosis Related Group is assigned.

The Australian National Diagnosis Related Groups departs from the use of principal diagnosis as the initial variable in the assignment of some groups. A hierarchy of all exceptions to the principal diagnosis-based assignment to a Major Diagnostic Category has been created. As a consequence, certain Australian National Diagnosis Related Groups are not unique to a Major Diagnostic Category. This requires both a Major Diagnostic Category and an Australian National Diagnosis Related Group to be generated per patient.

Context: Institutional health care: the generation of a Major Diagnostic Category to accompany each Australian National Diagnosis Related Group is a requirement of the latter as Diagnosis Related Groups are not unique.

Relational and representational attributes

Datatype: Numeric ***Representational form:*** CODE

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

Data domain: Australian National Diagnosis Related Groups (3M, Commonwealth).

Guide for use: Version effective 1 July each year

Verification rules:

Collection methods:

Related data: is derived from Date of birth, version 2
is derived from Admission date, version 3
is used in the derivation of Diagnosis related group, version 1
is derived from Infant weight, neonate, stillborn, version 3
is derived from Principal diagnosis - ICD-10-AM code, version 3
is derived from Additional diagnosis - ICD-10-AM code, version 4

Administrative attributes

Source document:

Source organisation: Department of Health and Family Services, Classification and Payments Branch

Major diagnostic category *(continued)*

National minimum data sets:

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

Comments: This data item has been created to reflect the development of Australian National Diagnosis Related Groups (as defined in the data element Diagnosis related group) by the Casemix Branch, Commonwealth Department of Health and Family Services. Due to the modifications in the Diagnosis Related Group logic for the Australian National Diagnosis Related Groups, it is necessary to generate the Major Diagnostic Category to accompany each Diagnosis Related Group. The construction of the pre-Major Diagnostic Category logic means Diagnosis Related Groups are no longer unique. Certain pre-Major Diagnostic Category Diagnosis Related Groups may occur in any of the 23 Major Diagnostic Categories. For example, liver transplant DRG 005, may occur in any of the Major Diagnostic Categories according to the principal diagnosis. AN-DRGs 950-954 (excluding AN-DRG 952 in most cases) also require the allocation of a Major Diagnostic Category according to the principal diagnosis.

AN-DRG Version 4.1 is under development and is expected to be available for implementation in November 1998.

Maternal medical conditions - ICD-10-AM code

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

NHIK identifier: 000090 ***Version number:*** 2

Data element type: DATA ELEMENT

Definition: Pre-existing maternal diseases and conditions, and other diseases, illnesses or conditions arising during the current pregnancy, that are not directly attributable to pregnancy but may significantly affect care during the current pregnancy and/or pregnancy outcome.

Context: Perinatal statistics: maternal medical conditions may influence the course and outcome of the pregnancy and may result in antenatal admission to hospital and/or treatment that could have adverse effects on the foetus and perinatal morbidity.

Relational and representational attributes

Datatype: Numeric ***Representational form:*** CODE

Field size: ***Min.*** 3 ***Max.*** 6 ***Representational layout:*** ANN.NN

Data domain: ICD-10-AM - disease codes

Guide for use: Examples of such conditions include essential hypertension, psychiatric disorders, diabetes mellitus, epilepsy, cardiac disease and chronic renal disease. There is no arbitrary limit on the number of conditions specified.

New South Wales, Australian Capital Territory, Victoria and the Northern Territory have implemented ICD-10-AM from 1 July 1998. Other States may continue to use ICD-9-CM until 30 June 1999.

Verification rules: Conditions should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM

Collection methods:

Related data: supersedes previous data element Maternal medical conditions - ICD-9-CM code, version 1

is used in conjunction with Complications of pregnancy - ICD-10-AM code, version 2

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 Perinatal Data Advisory Committee

National minimum data sets:

Comments:

Maternal medical conditions - ICD-9-CM code

Admin. status: SUPERSEDED 30/06/99

Identifying and definitional attributes

NHIK identifier: 000090 ***Version number:*** 1

Data element type: DATA ELEMENT

Definition: Pre-existing maternal diseases and conditions, and other diseases, illnesses or conditions arising during the current pregnancy, that are not directly attributable to pregnancy but may significantly affect care during the current pregnancy and/or pregnancy outcome.

Context: Perinatal statistics: maternal medical conditions may influence the course and outcome of the pregnancy and may result in antenatal admission to hospital and/or treatment that could have adverse effects on the foetus and perinatal morbidity.

Relational and representational attributes

Datatype: Numeric ***Representational form:*** CODE

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

Data domain: ICD-9-CM

Guide for use: Examples of such conditions include essential hypertension, psychiatric disorders, diabetes mellitus, epilepsy, cardiac disease and chronic renal disease. There is no arbitrary limit on the number of conditions specified.

Although this data element has been superseded by Maternal medical conditions - ICD-10-AM, Version 2, it remains an acceptable interim standard (until 30 June 1999) for use by those States and Territories that will not be implementing ICD-10-AM on 1 July 1998.

Verification rules:

Collection methods:

Related data: is used in conjunction with Complications of pregnancy - ICD-9-CM code, version 1

Administrative attributes

Source document: Australian Version of the International Classification of Diseases, 9th Revision, Clinical Modification, published by the National Centre for Classification in Health (1996) Sydney.

Source organisation: National Perinatal Data Advisory Committee

National minimum data sets:

Comments:

Nature of main injury - non-admitted patient

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

NHIK identifier: 000087 ***Version number:*** 1

Data element type: DATA ELEMENT

Definition: The nature of the injury chiefly responsible for the attendance of the person at the health care facility.

Context: Injury surveillance: injury diagnosis is necessary for purposes including epidemiological research, casemix studies and planning.This item together with item 'Bodily location of main injury' indicates the diagnosis.

Relational and representational attributes

Datatype: Numeric ***Representational form:*** CODE

Field size: ***Min.*** 2 ***Max.*** 4 ***Representational layout:*** NN or NN.N

Data domain:

01	Superficial (excludes eye [13])
02	Open wound (excludes eye [13])
03	Fracture (excludes tooth [21])
04	Dislocation (includes ruptured disc, cartilage, ligament)
05	Sprain or strain
06	Injury to nerve (includes spinal cord; excludes intracranial injury [20])
07	Injury to blood vessel
08	Injury to muscle or tendon
09	Crushing injury
10	Traumatic amputation (includes partial amputation)
11	Injury to internal organ
12	Burn or corrosion (excludes eye [13])
13	Eye injury (excludes foreign body in external eye [14.1], includes burns)
14.1	Foreign body in external eye
14.2	Foreign body in ear canal
14.3	Foreign body in nose
14.4	Foreign body in respiratory tract (excludes foreign body in nose [14.3])
14.5	Foreign body in alimentary tract
14.6	Foreign body in genitourinary tract
14.7	Foreign body in soft tissue
14.9	Foreign body, other/unspecified
20	Intracranial injury (includes concussion)
21	Dental injury (includes fractured tooth)
22	Drowning, immersion
23	Asphyxia or other threat to breathing (excludes drowning [22])
24	Electrical injury
25	Poisoning, toxic effect (excludes venomous bite [26])
26	Effect of venom, or any insect bite
27	Other specified nature of injury
28	Injury of unspecified nature
29	Multiple injuries of more than one 'nature'
30	No injury detected

Nature of main injury - non-admitted patient *(continued)*

Guide for use: If the full ICD-10-AM (or ICD-9-CM) code is used to code the injury, this item is not required (see data elements Principal diagnosis and Additional diagnosis). When coding to the full ICD-10-AM (or ICD-9-CM) code is not possible, use this item with the data element External cause of injury - non admitted patient, External cause of injury - human intent and Bodily location of main injury.

Select the item which best characterises the nature of the injury chiefly responsible for the attendance, on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one that comes first in the code list. A major injury, if present, should always be coded rather than a minor injury. If a major injury has been sustained (e.g. a fractured femur), along with one or more minor injuries (e.g. some small abrasions), the major injury should be coded in preference to coding 'multiple injuries'. As a general guide, an injury which, on its own, would be unlikely to have led to the attendance may be regarded as 'minor'.

If the nature of the injury code is 01 to 12 or 26 to 29 then data element Bodily location of main injury should be used to record the bodily location of the injury. If another code is used, bodily location is implicit or meaningless. Data element Bodily location of main injury, category 22 may be used as a filler to indicate that specific body region is not required.

New South Wales, Victoria, Australian Capital Territory and Northern Territory have implemented ICD-10-AM from 1 July 1998, other States may continue to use ICD-9-CM until 30 June 1999.

Verification rules: Left justified, zero filled.

Collection methods:

Related data: is used in conjunction with External cause - major external cause, version 3

is used in conjunction with External cause - human intent, version 3

is used in conjunction with Bodily location of main injury, version 1

Administrative attributes

Source document:

Source organisation: AIHW National Injury Surveillance Unit and National Data Standards for Injury Surveillance Advisory Group

National minimum data sets:

Injury surveillance from 1/07/89 to

Comments: This item is related to the ICD Injury and Poisoning classification (in ICD-9-CM and ICD-10-AM). Coding to the full ICD injury and poisoning classification (e.g. data element Principal diagnosis) is not available in most settings where basic injury surveillance is undertaken. This item, in combination with data element Bodily location of main injury is a practicable alternative. Data coded to the full ICD codes can be aggregated to match this item, facilitating data comparison. Further information on the national injury surveillance program can be obtained from the National Injury Surveillance Unit, Flinders University, Adelaide.

Neonatal death

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

NHIK identifier: 000101 ***Version number:*** 1

Data element type: DATA ELEMENT CONCEPT

Definition: The death of a live birth which occurs during the first 28 days of life. This may be subdivided into early neonatal deaths, occurring during the first seven days of life, and late neonatal deaths, occurring after the seventh day but before 28 completed days of life.

Context: Perinatal

Relational and representational attributes

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 Status of the baby, version 1

Administrative attributes

Source document: International Classification of Diseases, 10th Revision, WHO, 1992

Source organisation: National Perinatal Data Advisory Committee

National minimum data sets:

Perinatal collection from 1/07/97 to

Comments: Age at death during the first day of life (day zero) should be recorded in units of completed minutes or hours of life. For the second (day one), third (day two) and through 27 completed days of life, age at death should be recorded in days (WHO 1992).

Neonatal morbidity - ICD-10-AM code

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

NHIK identifier: 000102 ***Version number:*** 2

Data element type: DATA ELEMENT

Definition: Conditions or diseases of the baby.

Context: Perinatal statistics: morbidity of a baby is an important determinant of outcome and duration of hospital stay.

Relational and representational attributes

Datatype: Alphanumeric ***Representational form:*** CODE

Field size: ***Min.*** 3 ***Max.*** 6 ***Representational layout:*** ANN.NN

Data domain: ICD-10-AM

Guide for use: There is no arbitrary limit on the number of conditions specified.

New South Wales, Australian Capital Territory, Victoria and the Northern Territory have implemented ICD-10-AM from 1 July 1998. Other States may continue to use ICD-9-CM until 30 June 1999.

Verification rules: Conditions should be coded within chapter of Volume 1, ICD-10-AM

Collection methods:

Related data: is used in conjunction with Congenital malformations - BPA code, version 1

is used in conjunction with Congenital malformations - ICD-10-AM code, version 2

Administrative attributes

Source document: International Statistical Classification of Diseases and Related health Problems - 10th Revision, Australian Modification (1998) National Centre for Classification in Health, Sydney.

Source organisation: National Perinatal Data Advisory Committee

National minimum data sets:

Comments:

Neonatal morbidity - ICD-9-CM code

Admin. status: SUPERSEDED 30/06/99

Identifying and definitional attributes

NHIK identifier: 000102 ***Version number:*** 1

Data element type: DATA ELEMENT

Definition: Conditions or diseases of the baby.

Context: Perinatal statistics: morbidity of a baby is an important determinant of outcome and duration of hospital stay.

Relational and representational attributes

Datatype: Alphanumeric ***Representational form:*** CODE

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

Data domain: ICD-9-CM

Guide for use: There is no arbitrary limit on the number of conditions specified.

Although this data element has been superseded by Neonatal morbidity - ICD-10-AM, Version 2, it remains an acceptable interim standard (until 30 June 1999) for use by those States and Territories that will not be implementing ICD-10-AM on 1 July 1998.

Verification rules:

Collection methods:

Related data: is used in conjunction with Congenital malformations - ICD-9-CM code, version 1

is used in conjunction with Congenital malformations - BPA code, version 1

Administrative attributes

Source document: Australian Version of the International Classification of Diseases, 9th Revision, Clinical Modification, published by the National Centre for Classification in Health (1996) Sydney.

Source organisation: National Perinatal Data Advisory Committee

National minimum data sets:

Comments:

Nursing diagnosis

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

NHIK identifier: 000110 ***Version number:*** 2

Data element type: DATA ELEMENT

Definition: Nursing diagnosis is a clinical judgement about individual, family or community responses to actual or potential health problems/life processes. Nursing diagnoses provide the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable.

Context: Enables analysis of information by diagnostic variables especially in relation to the development of outcome information, Goal of care and Nursing intervention. Nursing diagnosis and the data element Nursing intervention have shown to be more predictive of resource use than client's functional status or medical diagnosis.

Relational and representational attributes

Datatype: Alphanumeric ***Representational form:*** CODE

Field size: ***Min.*** 3 ***Max.*** 11 ***Representational layout:*** N.N.N.N.N.N

Data domain: The North American Nursing Diagnosis Association (NANDA) Taxonomy, 1997-1998

Guide for use: Up to seven nursing diagnoses may be nominated, according to the following:

1. Nursing diagnosis most related to the principal reason for admission (one only)

2-6. Other nursing diagnoses of relevance to the current episode.

The NANDA codes should be used in conjunction with a nursing diagnosis text. The NANDA coding structure is a standard format for reporting nursing diagnosis. It is not intended in any way to change or intrude upon nursing practice, provided the information available can transpose to the NANDA codes for the Community Nursing Services Minimum Data Set - Australia (CNMDSA).

Verification rules:

Collection methods: In considering how nursing diagnosis could be implemented, agencies may opt to introduce systems transparent to the clinician if there is confidence that a direct and reliable transfer to NANDA codes can be made from information already in place.

Agencies implementing new information systems should consider the extent to which these can facilitate practice and at the same time lighten the burden of documentation. Direct incorporation of the codeset or automated mapping to it when the information is at a more detailed level are equally valid and viable options.

Related data: supserseds previous data element Nursing diagnosis, version 1

relates to the data element Nursing interventions, version 2

relates to the data element Goal of care, version 2

Nursing diagnosis *(continued)*

Administrative attributes

Source document: NANDA Nursing Diagnoses: Definitions and Classification 1997-1998. (1997)

North American Nursing Diagnosis Association.

Source organisation: Australian Council of Community Nursing Services

National minimum data sets:

Comments: The CNMDSA Steering Committee considered information from users of the data in relation to Nursing diagnosis. Many users have found the taxonomy wanting in its ability to describe the full range of persons and conditions seen by community nurses in the Australian setting. In the absence of an alternative taxonomy with wide acceptance, the CNMDSA Steering Committee has decided to retain NANDA. The University of Iowa has a written agreement with NANDA to expand the relevance of NANDA. The Australian Council of Community Nursing Services (ACCNS) has sought collaboration with a US project at the University of Iowa which is seeking to refine, extend, validate and classify the NANDA taxonomy.

Outcome of last previous pregnancy

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

NHIK identifier: 000114 ***Version number:*** 1

Data element type: DATA ELEMENT

Definition: Outcome of the most recent pregnancy preceding this pregnancy.

Context: Perinatal statistics: adverse outcome in previous pregnancy is an important risk factor for subsequent pregnancy.

Relational and representational attributes

Datatype: Numeric ***Representational form:*** CODE

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

Data domain:

1	Single live birth - survived at least 28 days
2	Single live birth - neonatal death (within 28 days)
3	Single stillbirth
4	Spontaneous abortion
5	Induced abortion
6	Ectopic pregnancy
7	Multiple live birth - all survived at least 28 days
8	Multiple birth - one or more neonatal deaths (within 28 days) or stillbirths

Guide for use: In the case of multiple pregnancy with foetal loss before 20 weeks, code on outcome of surviving foetus(es) beyond 20 weeks.

Verification rules:

Collection methods:

Related data: is a qualifier of Date of completion of last previous pregnancy, version 1

Administrative attributes

Source document:

Source organisation: National Perinatal Data Advisory Committee

National minimum data sets:

Comments: This data item is recommended by the World Health Organization. It is collected in some States and Territories.

Perinatal period

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

NHIK identifier: 000124 ***Version number:*** 1

Data element type: DATA ELEMENT CONCEPT

Definition: The perinatal period commences at 20 completed weeks (140 days) of gestation and ends 28 completed days after birth.

Context: Perinatal

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 Perinatal Data Advisory Committee

National minimum data sets:

Perinatal collection from 1/07/97 to

Comments: This definition of perinatal period differs from that recommended by WHO. In the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems, (WHO, 1992) the perinatal period is defined as commencing: 'at 22 completed weeks (154 days) of gestation (the time when birthweight is normally 500 g) and ends seven completed days after birth'.

At the time that WHO first recommended 500 g (and now 22 weeks) as the lower limits for reporting perinatal and infant mortality, Australia had already adopted legal and statistical definitions for birthweight (400 g) and gestational age (20 weeks) limits that were lower than the WHO limits. Also, the upper limit for the perinatal period in Australia was 28 days. These broader definitions in Australia obviously comply with, and extend, the WHO definitions.

To avoid unnecessary confusion between legal and statistical definitions in Australia, for the purposes of perinatal data collection it is recommended that the perinatal period commences at 20 completed weeks (140 days) of gestation and ends 28 completed days after birth.

Perineal status

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

NHIK identifier: 000125 ***Version number:*** 1

Data element type: DATA ELEMENT

Definition: State of the perineum following birth.

Context: Perinatal statistics: perineal laceration (tear) may cause significant maternal morbidity in the postnatal period. Episiotomy is an indicator of management during labour and, to some extent, of intervention rates.

Relational and representational attributes

Datatype: Numeric ***Representational form:*** CODE

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

Data domain:

1	Intact
2	1st degree laceration/vaginal graze
3	2nd degree laceration
4	3rd degree laceration
5	Episiotomy
6	Combined laceration and episiotomy
8	Other
9	Not stated

Guide for use:

Verification rules:

Collection methods:

Related data: is used in conjunction with Anaesthesia administered during labour, version 1
is used in conjunction with Presentation at birth, version 1
is used in conjunction with Method of birth, version 1

Administrative attributes

Source document:

Source organisation: National Perinatal Data Advisory Committee

National minimum data sets:

Comments:

Postpartum complication - ICD-10-AM code

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

NHIK identifier: 000131 ***Version number:*** 2

Data element type: DATA ELEMENT

Definition: Medical and obstetric complications of the mother occurring during the postnatal period up to the time of separation from care.

Context: Perinatal statistics: complications of the puerperal period may cause maternal morbidity, and occasionally death, and may be an important factor in prolonging the duration of hospitalisation after childbirth.

Relational and representational attributes

Datatype: Alphanumeric ***Representational form:*** CODE

Field size: ***Min.*** 3 ***Max.*** 6 ***Representational layout:*** ANN.NN

Data domain: ICD-10-AM

Guide for use: There is no arbitrary limit on the number of conditions specified.

New South Wales, Australian Capital Territory, Victoria and the Northern Territory have implemented ICD-10-AM from 1 July 1998. Other States may continue to use ICD-9-CM until 30 June 1999.

Verification rules: Complications should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM

Collection methods:

Related data: is used in conjunction with Complication of labour and delivery - ICD-10-AM code, version 2

Administrative attributes

Source document: International Statistical Classification of Diseases and Related health Problems - 10th Revision, Australian Modification (1998) National Centre for Classification in Health, Sydney.

Source organisation: National Perinatal Data Advisory Committee

National minimum data sets:

Comments: Examples of such conditions include postpartum haemorrhage, retained placenta, puerperal infections, puerperal psychosis, essential hypertension, psychiatric disorders, diabetes mellitus, epilepsy, cardiac disease and chronic renal disease.

Postpartum complication - ICD-9-CM code

Admin. status: SUPERSEDED 30/06/99

Identifying and definitional attributes

NHIK identifier: 000131 ***Version number:*** 1

Data element type: DATA ELEMENT

Definition: Medical and obstetric complications of the mother occurring during the postnatal period up to the time of separation from care.

Context: Perinatal statistics: complications of the puerperal period may cause maternal morbidity, and occasionally death, and may be an important factor in prolonging the duration of hospitalisation after childbirth.

Relational and representational attributes

Datatype: Numeric ***Representational form:*** CODE

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

Data domain: ICD-9-CM

Guide for use: There is no arbitrary limit on the number of conditions specified.

Postpartum complications should be coded within the Pregnancy, Childbirth, Puerperium chapter of Volume 1, ICD-9-CM.

Although this data element has been superseded by Postpartum complication - ICD-10-AM, Version 2, it remains an acceptable interim standard (until 30 June 1999) for use by those States and Territories that will not be implementing ICD-10-AM on 1 July 1998.

Verification rules:

Collection methods:

Related data: is used in conjunction with Complication of labour and delivery - ICD-9-CM code, version 1

Administrative attributes

Source document: Australian Version of the International Classification of Diseases, 9th Revision, Clinical Modification, published by the National Centre for Classification in Health (1996) Sydney.

Source organisation: National Perinatal Data Advisory Committee

National minimum data sets:

Comments: Examples of such conditions include postpartum haemorrhage, retained placenta, puerperal infections, puerperal psychosis, essential hypertension, psychiatric disorders, diabetes mellitus, epilepsy, cardiac disease and chronic renal disease.

Previous pregnancies

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

NHIK identifier: 000134 ***Version number:*** 1

Data element type: DATA ELEMENT

Definition: The total number of previous pregnancies, specified as pregnancies resulting in:

- live birth, or
- stillbirth - at least 20 weeks' gestational age or 400 g birthweight, or
- spontaneous abortion (less than 20 weeks' gestational age, or less than 400 g birthweight if gestational age is unknown), or
- induced abortion (termination of pregnancy before 20 weeks' gestation), or
- ectopic pregnancy.

Context: Perinatal statistics: the number of previous pregnancies is an important component of the woman's reproductive history. Parity may be a risk factor for adverse maternal and perinatal outcomes. A previous history of stillbirth or spontaneous abortion identifies the mother as high risk for subsequent pregnancies. A previous history of induced abortion may increase the risk of some outcomes in subsequent pregnancies.

Relational and representational attributes

Datatype: Numeric ***Representational form:*** QUANTITATIVE VALUE

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

Data domain: 2-digit numeric field representing the number of pregnancies for each of the categories above, or 99 for not stated

Guide for use: A pregnancy resulting in multiple births should be counted as one pregnancy.

In multiple pregnancies with more than one type of outcome, the pregnancies should be recorded in the following order:

- all live births
- stillbirth
- spontaneous abortion
- induced abortion
- ectopic pregnancy

Where the outcome was one stillbirth and one live birth, count as stillbirth.

Verification rules:

Collection methods:

Related data: is qualified by Date of completion of last previous pregnancy, version 1
is used in conjunction with Outcome of last previous pregnancy, version 1

Administrative attributes

Source document:

Previous pregnancies *(continued)*

Source organisation: National Perinatal Data Advisory Committee

National minimum data sets:

Comments:

Principal diagnosis - ICD-10-AM code

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

NHIK identifier: 000136 ***Version number:*** 3

Data element type: DATA ELEMENT

Definition: The diagnosis established after study to be chiefly responsible for occasioning the patient's episode of care in hospital (or attendance at the health care facility).

Context: Health services: the principal diagnosis is one of the most valuable health data elements. It is used for epidemiological research, casemix studies and planning purposes.

Admitted patients: The principal diagnosis is a major determinant in the classification of Australian National Diagnosis Related Groups and Major Diagnostic Categories.

Relational and representational attributes

Datatype: Alphanumeric ***Representational form:*** CODE

Field size: ***Min.*** 3 ***Max.*** 6 ***Representational layout:*** ANN.NN

Data domain: ICD-10-AM

Guide for use: The principal diagnosis must be determined in accordance with the Australian Coding Standards (ICD-10-AM). Each episode of admitted patient care must have a principal diagnosis and may have additional diagnoses.

The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status.

ICD-10-AM, the Australian modification of ICD-10 was published by the National Centre for Classification in Health in 1998 and implemented from July 1998. The classification is revised annually. The version current for the collection period is required.

New South Wales, Victoria, Australian Capital Territory and Northern Territory have implemented ICD-10-AM from 01/07/1998, other States may continue to use ICD-9-CM until 30/06/1999.

Verification rules: As a minimum requirement the Principal diagnosis code must be listed in ICD-10-AM.

Some diagnosis codes are too imprecise or inappropriate to be acceptable as a principal diagnosis and will group to 951Z, 955Z and 956Z in the Australian National Diagnosis Related Groups, Version 4. A list of these diagnosis codes is available from the Diagnosis Related Group Development Section, Classification and Payments Branch, Health Services Development Division, Department of Health and Family Services.

Diagnosis codes starting with a V, W, X or Y, describing the circumstances that cause an injury, rather than the nature of the injury, cannot be used as

Principal diagnosis - ICD-10-AM code *(continued)*

Verification rules (cont'd): principal diagnosis. Diagnosis codes which are morphology codes, cannot be used as principal diagnosis and will result in a fatal error.

Collection methods: A principal diagnosis should be recorded and coded upon separation, for each episode of patient care. The principal diagnosis is derived from and must be substantiated by clinical documentation.

Admitted patients: where the principal diagnosis is recorded prior to discharge (as in the annual census of public psychiatric hospital inpatients), it is the current provisional principal diagnosis. Only use the admission diagnosis when no other diagnostic information is available. The current provisional diagnosis may be the same as the admission diagnosis.

Related data: supersedes previous data element Principal diagnosis - ICD-9-CM code, version 2

relates to the data element Additional diagnosis - ICD-9-CM code, version 3

relates to the data element Additional procedures - ICD-9-CM code, version 3

relates to the data element External cause - major external cause, version 3

relates to the data element External cause - human intent, version 3

relates to the data element Diagnosis related group, version 1

is used in the derivation of Major diagnostic category, version 1

is used as an alternative to Nature of main injury - non-admitted patient, version 1

is an alternative to Bodily location of main injury, version 1

relates to the data element External cause - admitted patient - 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 Health Data Committee, National Centre for Classification in Health and National Data Standard for Injury Surveillance Advisory Group

National minimum data sets:

Institutional health care	from 1/07/89	to
Institutional mental health care	from 1/07/97	to
Community mental health care	from 1/07/98	to

Comments: This item is updated annually according to advice received from the National Centre for Classification in Health, and is consistent with the Australian Coding Standards (ICD-10-AM (1998)).

Principal diagnosis - ICD-9-CM code

Admin. status: SUPERSEDED 30/06/99

Identifying and definitional attributes

NHIK identifier: 000136 ***Version number:*** 2

Data element type: DATA ELEMENT

Definition: The diagnosis established after study to be chiefly responsible for occasioning the patient's episode of care in hospital (or attendance at the health care facility).

Context: Health services: the principal diagnosis is one of the most valuable health data elements. It is used for epidemiological research, casemix studies and planning purposes.

Relational and representational attributes

Datatype: Alphanumeric ***Representational form:*** CODE

Field size: ***Min.*** 3 ***Max.*** 6 ***Representational layout:*** ANN.NN

Data domain: ICD-9-CM

Guide for use: The classification is revised annually. The version current for the collection period is required. Australian editions of ICD-9-CM were published by the National Centre for Classification in Health in 1995 and 1996.

Although this data element has been superseded by Principal diagnosis - ICD-10-AM, Version 3, it remains an acceptable interim standard (until 30 June 1999) for use by those States and Territories that will not be implementing ICD-10-AM on 1 July 1998.

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

- start with a digit or a V
- be reported as per coding guidelines

Some diagnosis codes cannot be used, and will result in a fatal error. These relate to Diagnosis Related Groups 951, 955 and 956, which are too imprecise to be acceptable as principal diagnosis. A list of diagnosis codes grouped under these three Diagnosis Related Groups is available from the Diagnosis Related Group Development Section, Classification and Payments Branch, Health Services Development Division, Department of Health and Family Services.

Diagnosis codes starting with an E, describing the circumstances that cause an injury, rather than the nature of the injury, cannot be used as principal diagnosis

Diagnosis codes starting with an M are morphology codes, cannot be used as principal diagnosis and will result in a fatal error.

Collection methods: A principal diagnosis should be recorded for each episode of patient care. Where the principal diagnosis is recorded prior to discharge (as in the annual census of public psychiatric hospital inpatients), it is the current provisional principal diagnosis. Only use the admission diagnosis when no other diagnostic information is available. The current provisional diagnosis may be the same as the admission diagnosis.

Principal diagnosis - ICD-9-CM code *(continued)*

Related data: supersedes previous data element Principal diagnosis, version 1
relates to the data element Additional diagnosis - ICD-9-CM code, version 3
is a qualifier of Principal procedure, version 1
is a qualifier of Principal procedure, version 2
is a qualifier of Principal procedure - ICD-9-CM code, version 3
relates to the data element Additional procedures - ICD-9-CM code, version 3
relates to the data element External cause - major external cause, version 3
relates to the data element External cause - human intent, version 3
relates to the data element Place of occurrence of external cause of injury - admitted patient - ICD-9-CM, version 3
relates to the data element Place of occurrence of external cause of injury - non-admitted patient, version 3
relates to the data element Diagnosis related group, version 1
is used in the derivation of Major diagnostic category, version 1
is an alternative to Nature of main injury - non-admitted patient, version 1
is an alternative to Bodily location of main injury, version 1
relates to the data element External cause - admitted patient - ICD-9-CM code, version 3

Administrative attributes

Source document: Australian Version of the International Classification of Diseases, 9th Revision, Clinical Modification, published by the National Centre for Classification in Health (1996) Sydney.

Source organisation: National Health Data Committee, National Coding Centre and National Data Standard for Injury Surveillance Advisory Group

National minimum data sets:

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

Comments: This item is updated annually according to advice received from the National Coding Centre and is consistent with the Australian Coding Standards (Volume 4, Australian Version of ICD-9-CM (1995)).

Status of the baby

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

NHIK identifier: 000159 ***Version number:*** 1

Data element type: DATA ELEMENT

Definition: Status of the baby at birth.

Context: Perinatal statistics: essential to analyse outcome of pregnancy.

Relational and representational attributes

Datatype: Numeric ***Representational form:*** CODE

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

Data domain:

1 Live birth
2 Stillbirth (foetal death)
9 Not stated

Guide for use: Live birth is the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered liveborn (WHO, 1992 definition).

Stillbirth is a foetal death prior to the complete expulsion or extraction from its mother of a product of conception of 20 or more completed weeks of gestation or of 400 g or more birthweight; the death is indicated by the fact that after such separation the foetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. (This is the same as the WHO definition of foetal death, except that there are no limits of gestational age or birthweight for the WHO definition.)

Verification rules:

Collection methods:

Related data: relates to the data element concept Live birth, version 1
relates to the data element concept Stillbirth (foetal death), version 1
is used in conjunction with Resuscitation of baby, version 1
is qualified by Apgar score at 1 minute, version 1

Administrative attributes

Source document:

Source organisation: National Perinatal Data Advisory Committee

National minimum data sets:

Perinatal collection from 1/07/97 to

Comments:

Stillbirth (foetal death)

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

NHIK identifier: 000160 ***Version number:*** 1

Data element type: DATA ELEMENT CONCEPT

Definition: A foetal death prior to the complete expulsion or extraction from its mother of a product of conception of 20 or more completed weeks of gestation or of 400 g or more birthweight; the death is indicated by the fact that after such separation the foetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

Context: Perinatal

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 Perinatal Data Advisory Committee

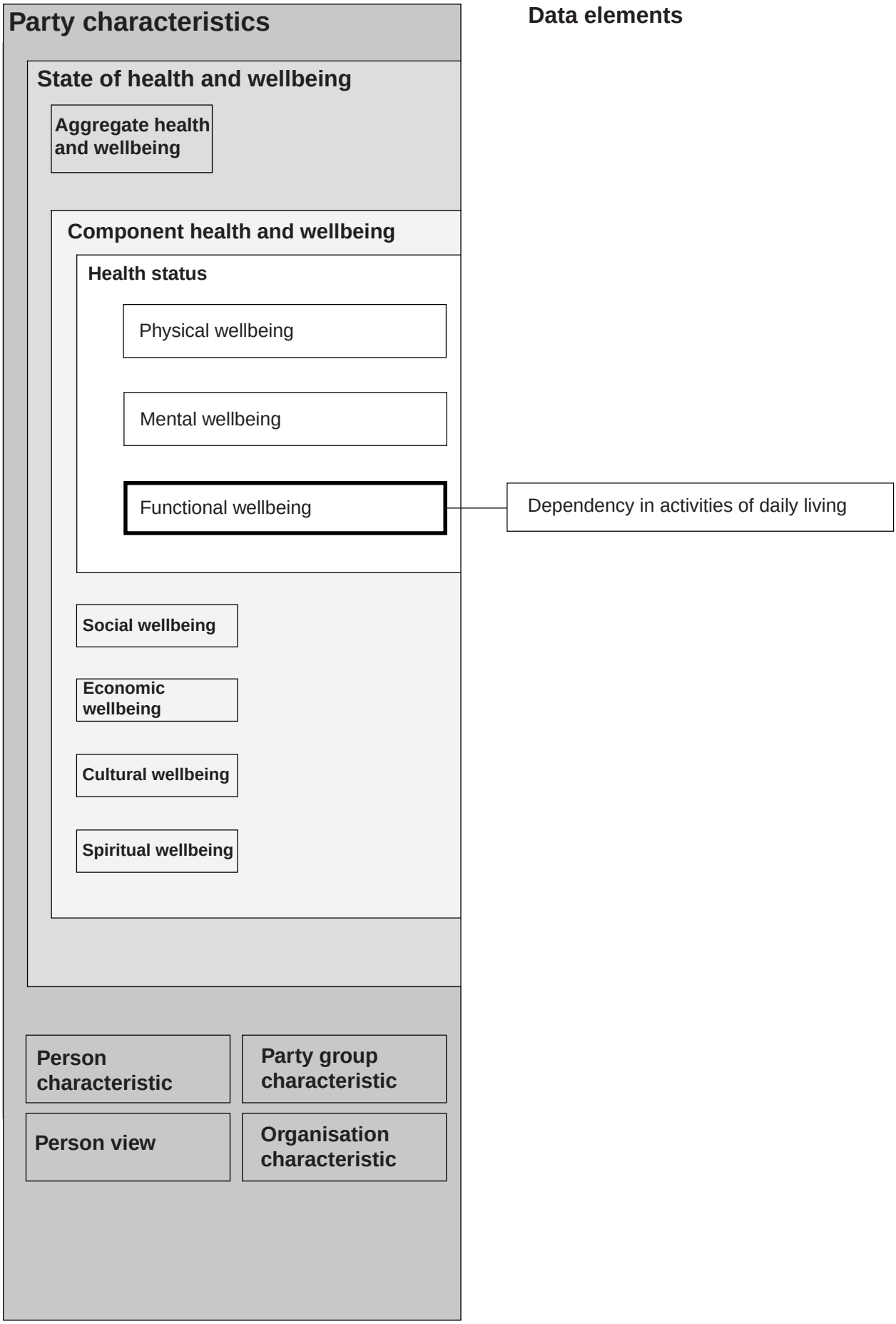
National minimum data sets:

Perinatal collection from 1/07/97 to

Comments: The WHO definition of live birth, and the legal definition used in Australian States and Territories, do not specify any lower limit for gestational age or birthweight. In practice, liveborn foetuses of less than 20 weeks' gestation are infrequently registered as live births. In analysing data from the perinatal collections, it is recommended that the same criteria of gestational age and birthweight should be used for live births and stillbirths. Births for which gestational age and birthweight have not been recorded (usually occurring outside hospitals) should be included in the perinatal collections if it seems likely that the criteria have been met.

Terminations of pregnancy performed at gestational ages of 20 or more weeks should be included in perinatal collections and should be recorded either as stillbirths or, in the unlikely event of showing evidence of life, as live births.

National Health Information Model entities



Dependency in activities of daily living

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

NHIK identifier: 000309 ***Version number:*** 2

Data element type: DATA ELEMENT

Definition: An indicator of a person's ability to carry out activities of daily living without assistance.

Context: Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored.

It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.

The following is an example of the minimum items, which are indicative of dependency.

Relational and representational attributes

Datatype: Numeric ***Representational form:*** CODE

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

Data domain: - All items must be completed. Select the appropriate code from the options provided for each of the above dependency items.

a) Mobility* 1 2 3 4
b) Toileting 1 2 3 4
c) Transferring 1 2 3 4 5
d) Bathing 1 2 3 4
e) Dressing 1 2 3 4
f) Eating 1 2 3 4 5
g) Bed mobility 1 2 3 4 5
h) Bladder continence 1 2 3 4 5 6
i) Bowel continence 1 2 3 4 5
j) Extra surveillance* 1 2 3 4 5 6 7
k) Technical care** not required, or time in minutes

Guide for use: Services may elect to adopt the measures as defined in this item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc. Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

All items must be completed

Dependency in activities of daily living *(continued)*

Guide for use (cont'd):

Select the appropriate code from the options provided for activities a) to g) when:

1 = Independent

2 = Requires observation or rare physical assistance

3 = Cannot perform the activity without some assistance

4 = Full assistance required (totally dependent); for bed mobility - a hoist is used

5 = For transferring - person is bedfast; for eating - tube-fed only; for bed mobility - 2 persons physical assist is required

* applies to walking, walking aid or wheelchair

Select the appropriate code for h) Bladder continence when:

1=Continent of urine (includes independence in use of device)

2=Incontinent less than daily

3=Incontinent once per 24 hour period

4=Incontinent 2-6 times per 24 hour period

5=Incontinent more than 6 times per 24 hour period

6=Incontinent more than once at night only

Select the appropriate code for I) Bowel continence when:

1 = Continent of faeces (includes independence in use of device)

2 = Incontinent less than daily

3 = Incontinent once per 24 hour period

4 = Incontinent regularly, more than once per 24 hour period

5 = Incontinent more than once at night only

Select the appropriate code for j) Extra surveillance* when:

1 = No additional attention required

2 = Less than 30 minutes individual attention per day

3 = More than 30 and more than or equal to 90 minutes individual attention per day

4 = Requires at least two hours intervention per week on an episodic basis

5 = More than 90 minutes but less than almost constant individual attention

6 = Requires almost constant individual attention

7 = Cannot be left alone at all

* Extra surveillance refers to behaviour, which requires individual attention and / or planned intervention. Some examples of extra surveillance are:

- aggressiveness;
- wandering;
- impaired memory or attention;

disinhibition and other cognitive impairment.

Dependency in activities of daily living *(continued)*

Guide for use (cont'd): Select the appropriate code for k) Technical care** not required, or time in minutes, when:

1 = No technical care requirements

or

____ = Daytime technical (minutes per week)

____ = Evening technical (minutes per week)

____ = Night-time technical (minutes per week)

____ = Infrequent technical (minutes per month)

** Technical care refers to technical tasks and procedures for which nurses receive specific education and which require nursing knowledge of expected therapeutic effect, possible side-effects, complications and appropriate actions related to each. In the community nursing setting, carers may undertake some of these activities within, and under surveillance, of a nursing care-plan. Some examples of technical care activities are:

- medication administration (including injections);
- dressings and other procedures;
- venipuncture;
- monitoring of dialysis;
- implementation of pain management technology.

Verification rules:

Collection methods: Commencement of Care episode. (There may be several visits in which assessment data are gathered.)

Related data: supersedes previous data element Client dependency, version 1

Administrative attributes

Source document:

Source organisation: Australian Council of Community Nursing Services

National minimum data sets:

Comments: There are a significant number of dependency instruments in use in the community and institutional care. The CNMDSA recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The data domain specified in this item consists of a number of standard elements, which can be used to map to and / or score from the majority of them.