Injury surveillance
National Minimum Data Set

National Health Data Dictionary, Version 12

National Health Data Committee

2003

Australian Institute of Health and Welfare
Canberra

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Introduction

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

The National Health Data Dictionary contains definitions of data elements that are included in NMDS collections in the health sector, including data elements used to derive some of the performance indicators required under Australian Health Care Agreements (bilateral agreements between the Commonwealth and State/Territory governments about funding and delivery of health services).

The following pages contain the Injury surveillance NMDS and its associated data elements and data element concepts.

Contents

Injury surveillance NMDS

Admin. status:	CURRENT 1/07/2000 Version number: 1
Metadata type:	NATIONAL MINIMUM DATA SET
Start date:	1 July 1989
End date:	
Latest evaluation date:	
Scope:	The scope of this minimum data set is patient-level data from selected emergency departments of hospitals and other settings.
Statistical units:	
Collection methodology:	
National reporting arrangements:	State and Territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation on an annual basis.
Periods for which data are collected and nationally collated:	Financial years ending 30 June each year
Data elements included:	Activity when injured, version 2 Bodily location of main injury, version 1 External cause – admitted patient, version 4 External cause – human intent, version 4 Narrative description of injury event, version 1 Nature of main injury – non-admitted patient, version 1 Place of occurrence of external cause of injury, version 5
Supporting data elements and data element concepts:	Admitted patient, version 3 Non-admitted patient, version 1
Data elements in common with other NMDSs:	See Appendix D
Scope links with other NMDSs:	
Source organisation:	National Health Information Management Group
Comments:	Statistical units are entities from or about which statistics are collected, or in respect of which statistics are compiled, tabulated or published.

Data elements included

Activity when injured

Identifying and Definitional Attributes

Knowledgebase ID: ***000002*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/00

Definition: The type of activity being undertaken by the person when injured.

Context: Injury surveillance:

Enables categorisation of injury and poisoning according to factors important for injury control. Necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research. This item is the basis for identifying work-related and sport-related injuries.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NN

Minimum size: 1

Maximum size: 2

Data domain:

0	Sports activity
00	Football, rugby
01	Football, Australian
02	Football, soccer
03	Hockey
04	Squash
05	Basketball
06	Netball
07	Cricket
08	Roller blading
09	Other and unspecified sporting activity
1	Leisure activity (excluding sporting activity)
2	Working for income
3	Other types of work
4	Resting, sleeping, eating or engaging in other vital activities
5	Other specified activities
6	Unspecified activities

Guide for use: Admitted patients:

Use the appropriate codes as fourth and fifth characters to Y93 when using the ICD-10-AM 3rd edition. Used with ICD-10-AM external cause codes V01 – Y34 and assigned according to the Australian Coding Standards.

Non-admitted patients:

To be used for injury surveillance purposes for non-admitted patients when it is not possible to use ICD-10-AM codes. Select the code which best characterises the type of activity being undertaken by the person when injured, on the basis

of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one that comes first in the code list.

Verification rules: Admitted patients:
To be used with ICD-10-AM external cause codes V01 – Y34 only.

Collection methods:

Related metadata: supersedes previous data element Activity when injured vers 1
is used in conjunction with Bodily location of main injury vers 1
relates to the data element Diagnosis onset type vers 1
is used in conjunction with External cause – human intent vers 4
is used in conjunction with External cause – non-admitted patient vers 4
is a qualifier of Narrative description of injury event vers 1
is used in conjunction with Nature of main injury – non-admitted patient vers 1

Administrative Attributes

Source document: ICD-10-AM 3rd edition

Source organisation: National Centre for Classification in Health
National Injury Surveillance Unit

Information model link:
NHIM Injury event

Data Set Specifications:	***Start date***	***End date***
NMDS – Admitted patient care	01/07/2000	
NMDS – Injury surveillance	01/07/2000	

Comments:

Bodily location of main injury

Identifying and Definitional Attributes

Knowledgebase ID: ***000086*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/96

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

Representational layout: NN

Minimum size: 2

Maximum size: 2

Data domain:

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

Guide for use:

If the full ICD-10-AM code is used to code the injury, this item is not required (see data elements Principal diagnosis and Additional diagnosis).

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

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 metadata: is used in conjunction with the data element Nature of main injury – non-admitted patient vers 1

Administrative Attributes

Source document:

Source organisation: National Injury Surveillance Unit

National Data Standards for Injury Surveillance Advisory Group

Information model link:

NHIM Physical wellbeing

Data Set Specifications:	***Start date***	***End date***
NMDS – Injury surveillance	01/07/1996	

Comments:

This item is related to the ICD-10-AM injury and poisoning classification. However, coding to the full ICD-10-AM injury and poisoning classification (see data element Principal diagnosis) is not available in most settings where basic injury surveillance is undertaken. This item, in combination with the data element Nature of main injury – non-admitted patient, is a practicable alternative. Data coded to the full ICD-10-AM codes can be aggregated to match this item, facilitating data comparison. Further information on the national injury surveillance program can be obtained from the National Injury Surveillance Unit, Flinders University, Adelaide.

External cause – admitted patient

Identifying and Definitional Attributes

Knowledgebase ID: ***000053*** ***Version No: 4***

Metadata type: Data Element

Admin. status: Current

01/07/98

Definition: Environmental event, circumstance or condition as the cause of injury, poisoning and other adverse effect.

Context: Institutional health care:

Enables categorisation of injury and poisoning according to factors important for injury control. This information is necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research. It is also used as a quality of care indicator of adverse patient outcomes.

Relational and Representational Attributes

Datatype: Alphanumeric

Representational form: Code

Representational layout: ANN.NN

Minimum size: 3

Maximum size: 6

Data domain: ICD-10-AM 3rd edition

Guide for use: This code must be used in conjunction with an injury or poisoning codes and can be used with other disease codes. Admitted patients should be coded to the complete ICD-10-AM classification.

An external cause code should be sequenced following the related injury or poisoning code, or following the group of codes, if more than one injury or condition has resulted from this external cause. Provision should be made to record more than one external cause if appropriate. External cause codes in the range W00 to Y34, except Y06 and Y07 must be accompanied by a place of occurrence code (data element Place of occurrence of external cause). External cause codes V01 to Y34 must be accompanied by an activity code (data element Activity when injured).

Verification rules: As a minimum requirement, the external cause codes must be listed in the ICD-10-AM classification.

Collection methods:

Related metadata: is used in conjunction with Activity when injured vers 2

is used in conjunction with Additional diagnosis vers 4

relates to the data element Diagnosis onset type vers 1

supersedes previous data element External cause – admitted patient – ICD-9-CM code vers 3

is used in conjunction with Place of occurrence of external cause vers 2

is used in conjunction with Principal diagnosis vers 3

Administrative Attributes

Source document: International Classification of Diseases – Tenth Revision – Australian Modification (3rd edition 2002) National Centre for Classification in Health, Sydney.

Source organisation: National Health Data Committee
National Centre for Classification in Health
National Data Standards for Injury Surveillance Advisory Group

Information model link:

NHIM Injury event

Data Set Specifications:	***Start date***	***End date***
NMDS – Admitted patient care	01/07/1998	
NMDS – Injury surveillance	01/07/1998	

Comments: An extended activity code is being developed in consultation with the National Injury Surveillance Unit, Flinders University, Adelaide.

External cause – human intent

Identifying and Definitional Attributes

Knowledgebase ID: ***000382*** ***Version No: 4***

Metadata type: Data Element

Admin. status: Current

01/07/98

Definition: The most likely role of human intent in the occurrence of the injury or poisoning as assessed by clinician.

Context: Injury surveillance:

Enables categorisation of injury and poisoning according to factors important for injury control. This information is necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NN

Minimum size: 2

Maximum size: 2

Data domain:

01	Accident – injury not intended
02	Intentional self-harm
03	Sexual assault
04	Maltreatment by parent
05	Maltreatment by spouse or partner
06	Other and unspecified assault
07	Event of undetermined intent
08	Legal intervention (including police) or operations of war
09	Adverse effect or complications of medical and surgical care
10	Other specified intent
11	Intent not specified

Guide for use: Select the item which best characterises the role of intent in the occurrence of the injury, on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one that comes first in the code list. This item must always be accompanied by an External cause – non-admitted patient code.

This data domain is for use in injury surveillance purposes only, when it is not possible to use a complete ICD-10-AM code (e.g. non-admitted patients in emergency departments).

Verification rules:

Collection methods:

Related metadata: is used in conjunction with Activity when injured vers 2
is used in conjunction with Bodily location of main injury vers 1
supersedes previous data element External cause – human intent vers 3
is used in conjunction with Narrative description of injury event vers 1
is used in conjunction with Nature of main injury – non-admitted patient vers 1
is used in conjunction with Place of occurrence of external cause of injury vers 5

Administrative Attributes

Source document:

Source organisation: National Health Data Committee
National Data Standards for Injury Surveillance Advisory Group

Information model link:

NHIM Injury event

Data Set Specifications:	***Start date***	***End date***
NMDS – Injury surveillance	01/07/1998	

Comments:

Narrative description of injury event

Identifying and Definitional Attributes

Knowledgebase ID: ***000099*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/96

Definition: A text description of the injury event.

Context: Injury surveillance:

The narrative of the injury event is very important to injury control workers as it identifies features of the event not revealed by coded data.

Relational and Representational Attributes

Datatype: Alphanumeric

Representational form: Text

Representational layout: A(100)

Minimum size: 0

Maximum size: 100

Data domain: Text up to 100 characters in length

Guide for use: Write a brief description of how the injury occurred. It should indicate what went wrong (the breakdown event), the mechanism by which this event led to injury and the object(s) or substance(s) most important in the event. The type of place at which the event occurred, and the activity of the person who was injured should also be indicated.

Verification rules:

Collection methods:

Related metadata: is qualified by Activity when injured vers 2

is qualified by External cause – human intent vers 4

Administrative Attributes

Source document:

Source organisation: National Injury Surveillance Unit

Information model link:

NHIM Injury event

Data Set Specifications:	***Start date***	***End date***
NMDS – Injury surveillance	01/07/1996	

Comments: This is a basic item for injury surveillance. The text description of the injury event is structured to indicate context, place, what went wrong and how the event resulted in injury. Further information on the national injury surveillance program can be obtained from the National Injury Surveillance Unit, Flinders University, Adelaide.

Nature of main injury – non-admitted patient

Identifying and Definitional Attributes

Knowledgebase ID: ***000087*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/96

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 data element Bodily location of main injury, indicates the diagnosis.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NN or NN.N

Minimum size: 2

Maximum size: 4

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

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). When coding to the full ICD-10-AM code is not possible, use this item with the data elements External cause of injury – non admitted patient, External cause of injury – human intent and Bodily location of main injury.

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

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

Verification rules: Left justified, zero filled.

Collection method

Related metadata: is used in conjunction with Bodily location of main injury vers 1

is used in conjunction with External cause – human intent vers 4

is used in conjunction with External cause – non-admitted patient vers 4

Administrative Attributes

Source document:

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

Information model link:

NHIM Physical wellbeing

Data Set Specifications:	***Start date***	***End date***
NMDS – Injury surveillance	01/07/1996	

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

Place of occurrence of external cause of injury

Identifying and Definitional Attributes

Knowledgebase ID: ***000384*** ***Version No: 5***

Metadata type: Data Element

Admin. status: Current

01/07/00

Definition: The place where the external cause of injury, poisoning or adverse effect occurred.

Context: Enables categorisation of injury and poisoning according to factors important for injury control. Necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N(N)

Minimum size: 1

Maximum size: 2

Data domain:

0	Home
1	Residential institution
2	School, other institution and public administration area
21	School
22	Health service area
23	Building used by general public or public group
3	Sports and athletics area
4	Street and highway
5	Trade and service area
6	Industrial and construction area
7	Farm
8	Other specified places
9	Unspecified place

Guide for use: Admitted patients:

Use the appropriate codes as fourth and fifth characters to Y92 when using the ICD-10-AM 3rd edition. Used with all ICD-10-AM external cause codes V01–Y89 and assigned according to the Australian Coding Standards.

Non-admitted patients:

to be used for injury surveillance purposes for non-admitted patients when it is not possible to use ICD-10-AM codes. Select the code which best characterises the type of place where the person was situated when the injury occurred on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one that comes first in the code list.

Verification rules: Admitted patients: to be used with ICD-10-AM external cause codes V01–Y89.

Collection methods:

Related metadata: relates to the data element Diagnosis onset type vers 1

is used in conjunction with External cause – admitted patient vers 4

is used in conjunction with External cause – non-admitted patient vers 4

supersedes previous data element Place of occurrence of external cause of injury – admitted patient vers 4

supersedes previous data element Place of occurrence of external cause of injury – non-admitted patient vers 3

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

National Centre for Classification in Health

AIHW National Injury Surveillance Unit

National Data Standards for Injury Surveillance Advisory Group

Information model link:

NHIM Other setting

Data Set Specifications:	***Start date***	***End date***
NMDS – Admitted patient care	01/07/2000	
NMDS – Injury surveillance	01/07/2000	

Comments: This data item has been modified to recognise the use of this information in injury surveillance. There has been no change to the coding requirements for patients admitted to hospital. The addition of an extended classification has been necessary to cater for the information requirements of the wide range of settings undertaking injury surveillance.

Place of occurrence for injury surveillance (type of place) has been extended to improve the identification of some important places where injuries occur. This also enables linking of the classification with ICD-10. Use of the number '0' has been avoided to ensure there are fewer problems with the data collection. This item will be reviewed when ICD-10 is adopted.

Further information on the national injury surveillance program may be obtained from the National Injury Surveillance Unit, Australian Institute of Health and Welfare, Adelaide. The recommended classification for injury surveillance purposes is as follows:

Injury surveillance – type of place:

1 Home (includes farm house)
2 Residential institution (excludes hospital – code 4)
3 School, other institutional or public administrative area
4 Hospital or other health service
5 Place of recreation (mainly for informal recreational activities)
6 Sports and athletics area (mainly for formal sports etc.)
7 Street or highway
8 Trade or service area
9 Industrial or construction area
10 Mine or quarry
11 Farm (excludes farm house – code 1)
12 Other specified places
13 Unspecified place

Supporting data elements and data element concepts

Admitted patient

Identifying and Definitional Attributes

Knowledgebase ID: ***000011*** ***Version No: 3***

Metadata type: Data Element Concept

Admin. status: Current

01/07/00

Definition: A patient who undergoes a hospital's admission process to receive treatment and/or care. This treatment and/or care is provided over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients). The patient may be admitted if one or more of the following apply:

- the patient's condition requires clinical management and/or facilities not available in their usual residential environment
- the patient requires observation in order to be assessed or diagnosed
- the patient requires at least daily assessment of their medication needs
- the patient requires a procedure(s) that cannot be performed in a stand-alone facility, such as a doctor's room without specialised support facilities and/or expertise available (e.g. cardiac catheterisation)
- there is a legal requirement for admission (e.g. under child protection legislation)
- the patient is aged nine days or less.

Context: Admitted patient care.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use: This data element concept should be used in conjunction with the definition of same-day patient in the data element Same-day patient.

Part 2 of Schedule 3 of the *National Health Act* (type C) professional attention may be used as a guide for the medical services not normally requiring hospital treatment and therefore not generally related to admitted patients.

All babies born in hospital are admitted patients.

Verification rules:

Collection methods:

Related metadata: supersedes previous data element Admitted patient vers 2

relates to the data element Care type vers 4

relates to the data element Newborn qualification status vers 2

relates to the data element Number of qualified days for newborns vers 2

relates to the data element Patient days vers 3

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Recipient role

Data Set Specifications: ***Start date*** ***End date***

Comments:

This definition includes all babies who are nine days old or less. However, all newborn days of stay are further divided into categories of qualified and unqualified for Australian Health Care Agreements and health insurance benefit purposes. A newborn day is acute (qualified) when a newborn meets at least one of the following criteria:

- is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient
- is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Health Minister for the purpose of the provision of special care
- remains in hospital without its mother
- is admitted to the hospital without its mother.

Acute (qualified) newborn days are eligible for health insurance benefit purposes and should be counted under the Australian Health Care Agreements. Days when the newborn does not meet these criteria are classified as unqualified (if they are nine days old or less) and should be recorded as such. Unqualified newborn days should not be counted under the Australian Health Care Agreements and are not eligible for health insurance benefit purposes.

Non-admitted patient

Identifying and Definitional Attributes

Knowledgebase ID: ***000104*** ***Version No: 1***

Metadata type: Data Element Concept

Admin. status: Current

01/07/94

Definition: A patient who does not undergo a hospital's formal admission process.

There are three categories of non-admitted patient:

- emergency department patient
- outpatient
- other non-admitted patient (treated by hospital employees off the hospital site – includes community/outreach services)

Context: Non-admitted patient care.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related metadata: relates to the data element concept Patient vers 1

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Recipient role

Data Set Specifications: ***Start date*** ***End date***

Comments: