

Foreword

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

This edition includes a new subject/keyword index to assist users to explore the Dictionary for national data standards in their areas of interest. Data elements in this edition continue to be presented in a format based on the ISO/IEC Standard 11179 *Specification and Standardization of Data Elements* – the international standard for defining data elements issued by the International Organization for Standardization and the International Electrotechnical Commission. As in Version 7.0, data elements are also presented according to their alignment to entities in the National Health Information Model.

All Australian health departments, the Australian Bureau of Statistics, the Australian Institute of Health and Welfare, the National Centre for Classification in Health, the Department of Veterans' Affairs, representatives of private hospitals and the private health insurance industry cooperate to produce in the Dictionary a set of core definitions and data items for use in all Australian health data collections. Use of the Dictionary will help ensure that data elements are collected uniformly from all services and jurisdictions throughout Australia and thereby improve the quality of information for community discussion and public policy debate on health issues in Australia.

The Dictionary was first made available in electronic form from July 1997 via the Knowledgebase – Australia's Health and Community Services Data Registry (formerly known as the National Health Information Knowledgebase or NHIK). The Knowledgebase has been updated to incorporate this eighth version of the Dictionary and is accessible via the Institute's world wide web home page (<http://www.aihw.gov.au>). The Knowledgebase has become a standard form of release for the Dictionary and, as world wide web access becomes more common, the requirement for this publication in hard copy has diminished. A downloadable copy of the Dictionary is also available from the Internet through the Publications area of the Institute's home page.

Thanks are due to Joe Christensen, Trish Ryan, and Alannah Smith of the Institute staff who have prepared the material for this eighth edition, and to all members of the National Health Data Committee who have overseen its preparation.

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

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

Richard Madden
Director
Australian Institute of Health and Welfare

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Introduction

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

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

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

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

The development and revision of the *National Health Data Dictionary* is coordinated by the National Health Data Committee.

The National Health Data Committee

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

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

The rules applied to each data element definition are designed to ensure that each definition is clear, concise and comprehensive, and provides sufficient information to ensure that all those who collect, provide, analyse and use the data understand its meaning. All definitions in the *National Health Data Dictionary* are presented in a format that is described in more detail at Appendix B.

The National Health Data Committee comprises representatives of:

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

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

A list of Committee members and their contact details (as at February 1999) is provided at Appendix A.

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

More information about the National Health Data Committee and its processes is available in the *National Health Data Committee: Procedures and Business Plan, 1999*. This document is available in hard copy from the National Health Data Committee Secretariat at the Australian Institute of Health and Welfare (see page 5 for Secretariat contact details) or can be downloaded from the Institute's world wide web site at <http://www.aihw.gov.au>.

The Knowledgebase – Australia’s Health and Community Services Data Registry

The Knowledgebase – Australia’s Health and Community Services Data Registry (formerly known as the National Health Information Knowledgebase or NHIK) is an electronically accessible repository of *National Health Data Dictionary* data element definitions. The National Health Information Management Group is the organisation authorised to register *National Health Data Dictionary* data elements (that is, the Registration Authority) in the Knowledgebase. The Knowledgebase is also a data repository for other Registration Authorities approved by the National Health Information Management Group. The Knowledgebase integrates and presents information about:

- the National Health Information Model
- the National Community Services Information Model
- the National Health Data Dictionary
- the National Community Services Data Dictionary
- National Minimum Data Sets
- a national directory of data collections
- the National Health Information Work Program.

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

All data definitions that are included in Version 8.0 of the *National Health Data Dictionary* are available on the Knowledgebase. Draft data definitions under development by the National Health Data Committee are also available on the Knowledgebase under the section titled National Health Data Committee as Registration Authority, but are not available in print form.

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

The Internet address for the Knowledgebase – Australia’s Health and Community Services Data Registry is <http://www.aihw.gov.au>

National Minimum Data Sets

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

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

Version 8.0 of the *National Health Data Dictionary*, identifies data elements from the following National Minimum Data Sets (NMDS):

- Institutional health care NMDS
- Institutional mental health care NMDS

- Community mental health care NMDS
- Injury surveillance NMDS
- Elective surgery waiting times NMDS (formerly named the Waiting times NMDS)
- Emergency Department waiting times NMDS ***(New!)**
- Health labour force NMDS
- Perinatal NMDS
- Palliative care NMDS.

Descriptions of these National Minimum Data Sets can be found at Appendix H and also on the Knowledgebase.

Version 8.0

This version of the Dictionary contains 245 data definitions, including 15 new data elements and 12 new versions of data elements that have been agreed by the members of the National Health Data Committee, and endorsed by the National Health Information Management Group. A full alphabetical listing of all data elements in this version of the Dictionary is provided at the front of this publication. In addition, a new subject/keyword index to this version of the Dictionary is provided at Appendix K.

This hard copy publication of Version 8.0 only includes data elements that are current as at 1 July 1999. However, all data elements including those that have been superseded or rendered obsolete by new data elements or new versions of data elements in Version 8.0, are available on the Knowledgebase.

As in Version 7.0, data definitions are presented in a format based on ISO/IEC Standard 11179 *Specification and Standardization of Data Elements* – the international standard for defining data elements issued by the International Organization for Standardization and the International Electrotechnical Commission. This format is explained in detail at Appendix B.

Version 8.0 continues the format of Version 7.0 in that all data elements are organised and presented according to their alignment with entities in the National Health Information Model (Version 2.0, Draft). The mapping of data elements to the Model is being progressively refined following consultation with stakeholders in the national health information field. This presentation format is designed to enhance the integration of the Model with the data elements, thus providing a more complete framework for understanding and implementing existing definitions and for identifying areas for further data development activity. A copy of the full National Health Information Model (Version 2.0, Draft) follows this introductory section.

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

Feedback

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

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

Secretariat contact details

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

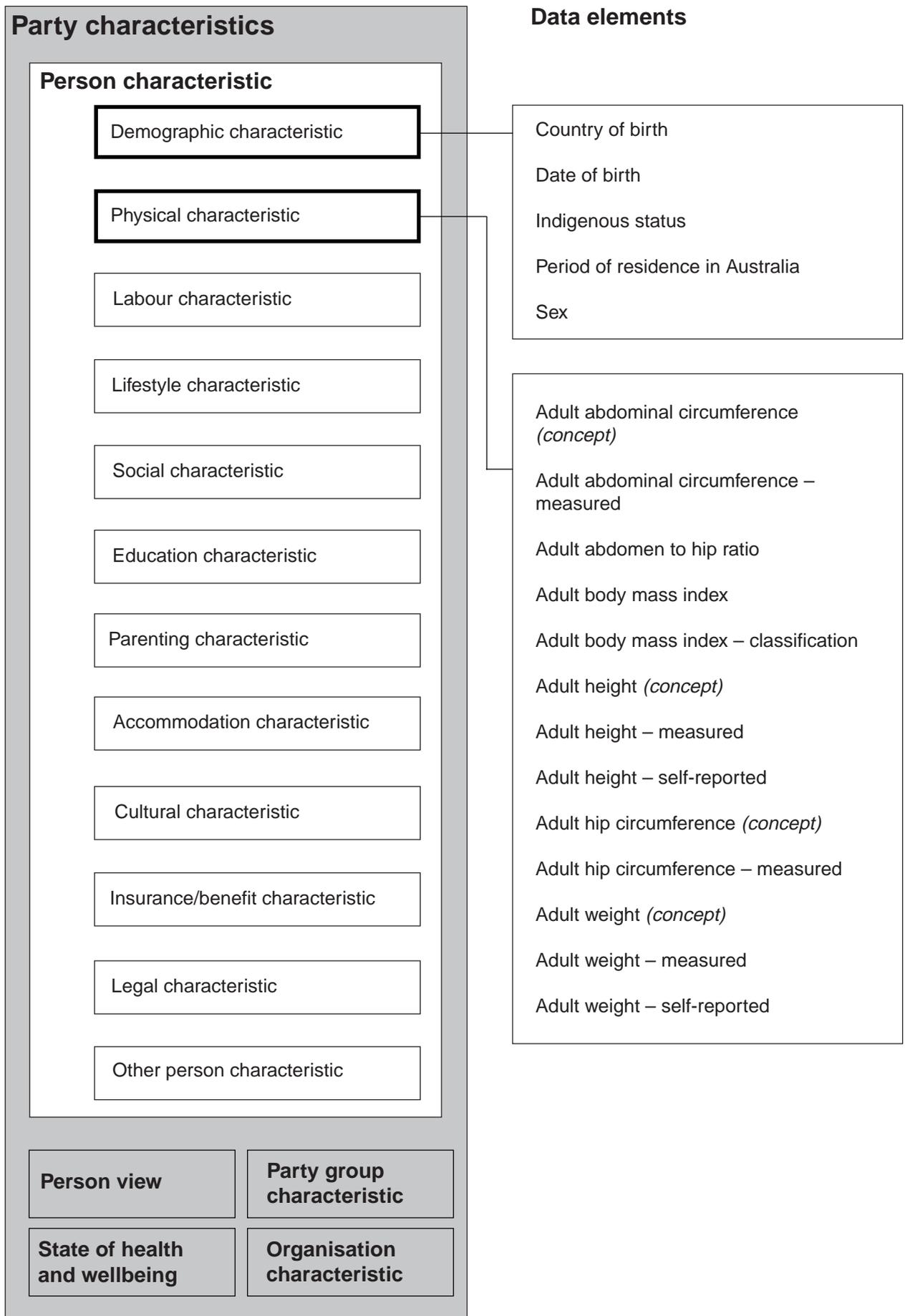
Joe Christensen Phone: 02 6244 1148
 Fax: 02 6244 1255
 Email: joe.christensen@aihw.gov.au

Trish Ryan Phone: 02 6244 1109
 Fax: 02 6244 1255
 Email: trish.ryan@aihw.gov.au

Alannah Smith Phone: 02 6244 1019
 Fax: 02 6244 1255
 Email: alannah.smith@aihw.gov.au

Postal address: NHDC Secretariat
 AIHW
 GPO Box 570
 Canberra ACT 2601

National Health Information Model entities



Country of birth

Admin. status: CURRENT 1/07/94

Identifying and definitional attributes

Knowledgebase ID: 000035 *Version number:* 2

Data element type: DATA ELEMENT

Definition: The country in which the person was born.

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

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain: Australian Standard Classification of Countries for Social Statistics (ASCCSS) 4-digit (individual country) level. ABS catalogue no. 1269.0

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

Verification rules:

Collection methods:

Related data: supersedes previous data element Country of birth, version 1

Administrative attributes

Source document: ABS Catalogue No. 1269.0

Source organisation: Australian Bureau of Statistics

National minimum data sets:

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

Comments:

Date of birth

Admin. status: CURRENT 1/07/94

Identifying and definitional attributes

Knowledgebase ID: 000036 *Version number:* 2

Data element type: DATA ELEMENT

Definition: The date of birth of the person.

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

Relational and representational attributes

Datatype: Numeric *Representational form:* DATE

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

Data domain: Valid dates

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

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

- be <= Admission date, otherwise resulting in a fatal error

- not be null

- be consistent with diagnoses and procedure codes, for records to be grouped, otherwise resulting in a fatal error.

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

Related data: supersedes previous data element Date of birth, version 1
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
Health labourforce	from 1/07/89 to
Institutional mental health care	from 1/07/97 to
Perinatal	from 1/07/97 to
Community mental health care	from 1/07/2000 to
Palliative care	from 1/07/2000 to

Comments:

Indigenous status

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000001 *Version number:* 2

Data element type: DATA ELEMENT

Definition: An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she lives (High Court of Australia in *Commonwealth V Tasmania* (1983) 46 ALR).

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

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

1	Indigenous – Aboriginal but not Torres Strait Islander origin
2	Indigenous – Torres Strait Islander but not Aboriginal origin
3	Indigenous – Aboriginal and Torres Strait Islander origin
4	Not indigenous – not Aboriginal or Torres Strait Islander origin
9	Not stated (not for use in primary data collection)

Guide for use:

Verification rules:

Collection methods: There are three components to the definition:

- descent
- self identification
- community acceptance

It is not possible to collect the three components of the definition in a single question. The Australian Bureau of Statistics (ABS) proposes that the focus of a single question should be the descent, the first component of the definition. The ABS therefore proposes the use of the following alternative questions, depending on whether the person is present or not.

Where the person is present

‘Are you of Aboriginal or Torres Strait Islander origin?’; or

where the person is not present and someone who knows the person well responds for them,

‘Is the person of Aboriginal or Torres Strait Islander origin?’

Indigenous status (*continued*)

Collection methods: The ABS recommends collection of response in tick boxes, e.g.;

(*cont'd*)

- No

- Yes Aboriginal

- Yes Torres Strait Islander.

Persons of both Aboriginal and Torres Strait Islander origin will mark 'Yes' to both questions enabling the responses to be coded.

Self reporting of descent is not equivalent to self reporting of identity but because of the absence of a second 'identity' question some respondents will interpret the 'origin' question to mean both descent and identification. What identification in the context of the variable Indigenous Status should measure is an individual's self assessed historical and cultural affiliation.

The code in the not stated classification is for use in administrative collections when transferring data from data sets where the item has not been collected. It is not to be used in primary collections.

Related data: supersedes previous data element Aboriginality, version 1

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

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

Comments: The ABS has revised its interim standard for statistics on indigenous status aimed at providing a conceptual framework for the collection of information about Aboriginal or Torres Strait Islander peoples.

Period of residence in Australia

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000126 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Length of time in years.

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

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

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

Data domain:

00	Under one year residence in Australia
01-97	One to 97 years residence in Australia
98	Born in Australia
99	Unknown

Guide for use:

Verification rules:

Collection methods: This information may be obtained either from:

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

Related data: is used in conjunction with Country of birth, version 2

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

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

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

Sex

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000149 *Version number:* 2

Data element type: DATA ELEMENT

Definition: The sex of the person.

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

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

1	Male
2	Female
3	Indeterminate
9	Not stated / inadequately described

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

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

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

What is your (the person's) sex?

___ Male

___ Female

The term 'sex' refers to the biological differences between males and females, while the term 'gender' refers to the socially expected/perceived dimensions of behaviour associated with males and females – masculinity and femininity. The ABS advises that the correct terminology for this data element is sex. Information collection for transsexuals and people with transgender issues should be treated in the same manner. To avoid problems with edits, transsexuals undergoing a sex change operation should have their sex at time of hospital admission recorded.

Related data: supersedes previous data element Sex, version 1
is used in the derivation of Diagnosis related group, version 1

Sex (continued)

Administrative attributes

Source document: ABS Directory of concepts and standards for social, labour and demographic statistics, 1993

Source organisation: National Health Data Committee

National minimum data sets:

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

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

Adult abdominal circumference

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000371 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

Definition: A person's abdominal circumference.

Context:

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 Adult abdominal circumference – measured, version 1

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

Comments:

Adult abdominal circumference – measured

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000372 *Version number:* 1

Data element type: DATA ELEMENT

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

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

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

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

Context: Public health and health care.

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 3 *Max.* 4 *Representational layout:* NNN.N

Data domain:

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

Verification rules:

Collection methods: Measurement protocol:

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

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

Adult abdominal circumference – measured (*continued*)

Collection methods
(*cont'd*):

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

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

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

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

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

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

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

Validation and quality control measures:

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

Within- and, if relevant, between-observer variability should be reported. They can be assessed by the same (within -) or different (between-) observers repeating the measurement, on the same subjects, under standard conditions after a short time interval. The standard deviation of replicate measurements

Adult abdominal circumference – measured (*continued*)

Collection methods (cont'd): (technical error of measurement (Pederson & Gore 1996)) between observers should not exceed 2% and be less than 1.5% within observers.

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

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

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

Administrative attributes

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

Source organisation: World Health Organization (see also Comments)

National minimum data sets:

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

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

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

Presentation of data:

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

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

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

Adult abdominal circumference – measured (*continued*)

Comments (cont'd): Abdom < 60 cm
60 cm = Abdom < 65 cm
65 cm = Abdom < 70 cm
... in 5 cm categories
105 cm = Abdom < 110 cm
Abdom = 110 cm

Adult abdomen to hip ratio

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000373 *Version number:* 1

Data element type: DATA ELEMENT

Definition: A person's abdomen to hip ratio.
Adult abdomen to hip ratio is a continuous variable.
Adult abdomen to hip ratio is calculated by: abdominal circumference (cm) divided by hip circumference (cm).

Context: Public health and health care.
Body fat distribution has emerged as an important predictor of obesity-related morbidity and mortality. Abdominal obesity, which is more common in men than women, has, in epidemiological studies, been closely associated with conditions such as coronary heart disease, stroke, non-insulin dependent diabetes mellitus and high blood pressure.
Abdomen to hip ratio (AHR) can be used:
- to indicate the prevalence of abdominal obesity and its sociodemographic distribution (problem identification);
- to evaluate health promotion and disease prevention programs (assessment of interventions);
- to monitor progress towards National Health Goals and Targets;
- to ascertain determinants and consequences of abdominal obesity; and
- in nutritional surveillance and long-term planning.
Cutoff points for abdomen to hip ratio that may define increased risk of cardiovascular disease and all cause mortality range from 0.9 to 1.0 for men and 0.8 to 0.9 for women (Croft et al. 1995; Bray 1987; Bjorntorp 1985). These values are based primarily on evidence of increased risk of death in European populations, and may not be appropriate for all age and ethnic groups.
In Australia and New Zealand, the cutoffs of > 0.9 for males and > 0.8 for females were used in the Australian Bureau of Statistics' 1995 *National Nutrition Survey*.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

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

Data domain:

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

Verification rules:

Adult abdomen to hip ratio (*continued*)

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

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

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

is calculated using Adult abdominal circumference – measured, version 1

Administrative attributes

Source document:

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

National minimum data sets:

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

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

Presentation of data:

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

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

Adult body mass index

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000367 *Version number:* 1

Data element type: DATA ELEMENT

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

Adult body mass index is a continuous variable.

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

Context: Public health and health care.

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

In population based surveys, BMI may be used:

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

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 3 *Max.* 4 *Representational layout:* NN.NN* / NN.N**

Data domain:

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

Verification rules:

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

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

BMI calculated from measured height and weight should be distinguished from BMI calculated from self-reported height and/or weight. When either

Adult body mass index (*continued*)

Collection methods (cont'd): self-reported height or self-reported weight is used in the calculation, BMI should be recorded as self-reported BMI.

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

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

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

Related data:

- is calculated using Adult height – measured, version 1
- is calculated using Adult height – self-reported, version 1
- is calculated using Adult weight – measured, version 1
- is calculated using Adult weight – self-reported, version 1
- is used in the derivation of Adult body mass index – classification, version 1

Administrative attributes

Source document:

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

National minimum data sets:

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

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

Presentation of data:

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

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

Adult body mass index (*continued*)

Comments (cont'd): Body mass index can be calculated from measured height and weight, or self-reported height and weight.

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

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

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

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

Adult body mass index – classification

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000368 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The category of weight deficit or excess.

Context: Public health and health care.

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

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

1	Grade 3 thinness (BMI < 16.00)
2	Grade 2 thinness (BMI 16.00-16.99)
3	Grade 1 thinness (BMI 17.00-18.49)
4	Normal range (BMI 18.50-19.99)
5	(BMI 20.00-24.99)
6	Grade 1 overweight (BMI 25.00-29.99)
7	Grade 2 overweight (BMI 30.00-39.99)
8	Grade 3 overweight (BMI > or = 40.00)

(WHO Expert Committee 1995; NHMRC 1984, 1985)

Guide for use:

Verification rules:

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

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

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

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

Administrative attributes

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

Adult body mass index – classification (*continued*)

Source organisation: World Health Organization (see also Comments)

National minimum data sets:

Comments:

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

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

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

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

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

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

The WHO may revise this classification to:

- | | |
|---|------------------------------------|
| 1 | Grade 3 thinness (BMI < 16.00) |
| 2 | Grade 2 thinness (BMI 16.00 16.99) |
| 3 | Grade 1 thinness (BMI 17.00 18.49) |
| 4 | Normal range (BMI 18.50 24.99) |
| 5 | Overweight (BMI 25.00 29.99) |
| 6 | Obesity Grade 1 (BMI 30.00 34.99) |

Adult body mass index – classification (*continued*)

Comments (cont'd): 7 Obesity Grade 2 (BMI 35.00 44.99)

8 Obesity Grade 3 (BMI = 45.00)

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

Presentation of data:

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

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

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

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

Adult height

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000361

Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: A person's height.

Context:

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 Adult height – measured, version 1

relates to the data element Adult height – self-reported, version 1

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

Comments:

Adult height – measured

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000362 *Version number:* 1

Data element type: DATA ELEMENT

Definition: A person's measured height.

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

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

Context: Public health and health care.

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 3 *Max.* 4 *Representational layout:* NNN.N

Data domain:

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

Verification rules:

Collection methods: Measurement protocol:

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

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

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

The subject should be measured without shoes (i.e. is barefoot or wears thin socks) and wears little clothing so that the positioning of the body can be seen. Anything that may affect or interfere with the measurement should be

Adult height – measured (*continued*)

Collection methods (cont'd):

noted on the data collection form (e.g. hairstyles and accessories, or physical problems).

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

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

The movable headboard is brought onto the top of the head with sufficient pressure to compress the hair.

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

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

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

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

Validation and quality control measures:

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

Adult height – measured (*continued*)

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

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

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

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

Administrative attributes

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

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

National minimum data sets:

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

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

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

Presentation of data:

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

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and

Adult height – measured (*continued*)

Comments (cont'd): 95. To estimate the 5th and 95th centiles a sample size of at least 200 is recommended for each group for which the centiles are being specified.

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

Ht <140 cm
140 cm = Ht < 145 cm
145 cm = Ht < 150 cm
... in 5 cm categories
185 cm = Ht < 190 cm
Ht = 190 cm

Adult height – self-reported

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000363 *Version number:* 1

Data element type: DATA ELEMENT

Definition: A person's self-reported height.

Context: Public health and health care.

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 2 *Max.* 3 *Representational layout:* NNN

Data domain:

Guide for use: If self-reported height is unknown, code 888
If self-reported height is not responded to, code 999

Verification rules:

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

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

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

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

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

Adult height – self-reported (*continued*)

Collection methods nnn.x where $x > 5$ – round up, e.g. 172.7 cm would be rounded to 173 cm.

(cont'd): nnn.x where $x = 5$ – round to the nearest even number, e.g. 172.5 cm would be rounded to 172 cm, while 173.5 cm would be rounded to 174 cm.

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

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

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

Administrative attributes

Source document:

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

National minimum data sets:

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

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

Presentation of data:

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

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

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

Ht <140 cm

140 cm = Ht < 145 cm

Adult height – self-reported (*continued*)

Comments (cont'd): 145 cm = Ht < 150 cm

... in 5 cm categories

185 cm = Ht < 190 cm

Ht = 190 cm

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

Adult hip circumference

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000369

Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: A person's hip circumference

Context:

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 Adult hip circumference – measured, version 1

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

Comments:

Adult hip circumference – measured

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000370 *Version number:* 1

Data element type: DATA ELEMENT

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

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

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

Context: Public health and health care.

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

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 3 *Max.* 4 *Representational layout:* NNN.N

Data domain:

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

Verification rules:

Collection methods: Measurement protocol:

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

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

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

The subject stands erect with arms at the sides, feet together and the gluteal muscles relaxed. The measurer sits at the side of the subject so that the level of maximum posterior extension of the buttocks can be seen. An inelastic tape is placed around the buttocks in a horizontal plane. To ensure contiguity of the two parts of the tape from which the circumference is to be determined,

Adult hip circumference – measured (*continued*)

Collection methods (cont'd):

the cross-handed technique of measurement, as described by Norton et al. (1996), should be used. Ideally an assistant will check the position of the tape on the opposite side of the subject's body. The tape is in contact with the skin but does not compress the soft tissues. Fatty aprons should be excluded from the hip circumference measurement.

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

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

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

Validation and quality control measures:

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

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

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

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

Related data:

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

Administrative attributes

Source document:

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

Adult hip circumference – measured (*continued*)

Source organisation: World Health Organization (see also Comments)

National minimum data sets:

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

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

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

Presentation of data:

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

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

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

Adult weight

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000364

Version number: 1

Data element type: DATA ELEMENT CONCEPT

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

Context:

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 Adult weight – measured, version 1
relates to the data element Adult weight – self-reported, version 1

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

Comments:

Adult weight – measured

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000365 *Version number:* 1

Data element type: DATA ELEMENT

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

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

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

Context: Public health and health care.

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 3 *Max.* 4 *Representational layout:* NNN.N

Data domain:

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

Verification rules:

Collection methods: Measurement protocol:

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

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

Heavy jewellery should be removed and pockets emptied. Light indoor clothing can be worn, excluding shoes, belts, and sweater.

If the subject has had one or more limbs amputated, record this on the data collection form and weigh them as they are. If they are wearing an artificial limb, record this on the data collection form but do not ask them to remove it. Similarly, if they are not wearing the limb, record this but do not ask them to put it on.

Adult weight – measured (*continued*)

Collection methods (cont'd):

During weighing, any variations from light indoor clothing (e.g. heavy clothing, such as kaftans or coats worn because of cultural practices) should be noted on the data collection form. Adjustments for non-standard clothing (i.e. other than light indoor clothing) should only be made in the data checking/cleaning stage prior to data analysis.

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

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

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

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

Validation and quality control measures:

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

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

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

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

Related data:

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

Adult weight – measured (*continued*)

Administrative attributes

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

Source organisation: World Health Organization (see also Comments)

National minimum data sets:

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

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

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

Presentation of data:

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

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

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

Adult weight – self-reported

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000366 *Version number:* 1

Data element type: DATA ELEMENT

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

Context: Public health and health care.

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 2 *Max.* 3 *Representational layout:* NNN

Data domain:

Guide for use: If self-reported body mass (weight) is unknown, code 888
If self-reported body mass (weight) is not responded to, code 999

Verification rules:

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

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

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

Rounding to the nearest 1 kg will be required for measures converted to metric prior to data entry, and may be required for data reported in metric units to a greater level of precision than the nearest 1 kg. The following rounding

Adult weight – self-reported (*continued*)

Collection methods (cont'd): conventions are desirable to reduce systematic over reporting (Armitage and Berry 1994):
nnn.x where $x < 5$ – round down, e.g. 72.2 kg would be rounded to 72 kg.
nnn.x where $x > 5$ – round up, e.g. 72.7 kg would be rounded to 73 kg.
nnn.x where $x = 5$ – round to the nearest even number, e.g. 72.5 kg would be rounded to 72 kg, while 73.5 kg would be rounded to 74 kg.
It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.
National health data elements currently exist for sex, date of birth, country of birth and Indigenous Status. Data elements are being developed for physical activity and smoking.

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

Administrative attributes

Source document:

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

National minimum data sets:

Comments: Submitting organisation: The Expert Working Group on Data Standards for Indicators of Body Fatness in Australian Adults through the National Centre for Monitoring Cardiovascular Disease, Australian Institute of Health and Welfare.
Date of submission: October 1997
This data element applies to persons aged 18 years or older. It is recommended for use in population surveys when it is not possible to measure weight.
Presentation of data:
Means and 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. Estimates based on sample surveys may need to take into account sampling weights.
For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles a sample size of at least 200 is recommended for each group for which the centiles are being specified.
For some reporting purposes, it may be desirable to present weight data in categories. It is recommended that 5 kg groupings are used for this purpose. Weight data should not be rounded before categorisation. The following

Adult weight – self-reported (*continued*)

Comments (cont'd): categories may be appropriate for describing the weights of Australian men and women, although the range will depend on the population. The World Health Organization's range for weight is **30-140 kg**.

Wt < 30 kg

30 kg = Wt < 35 kg

35 kg = Wt < 40 kg

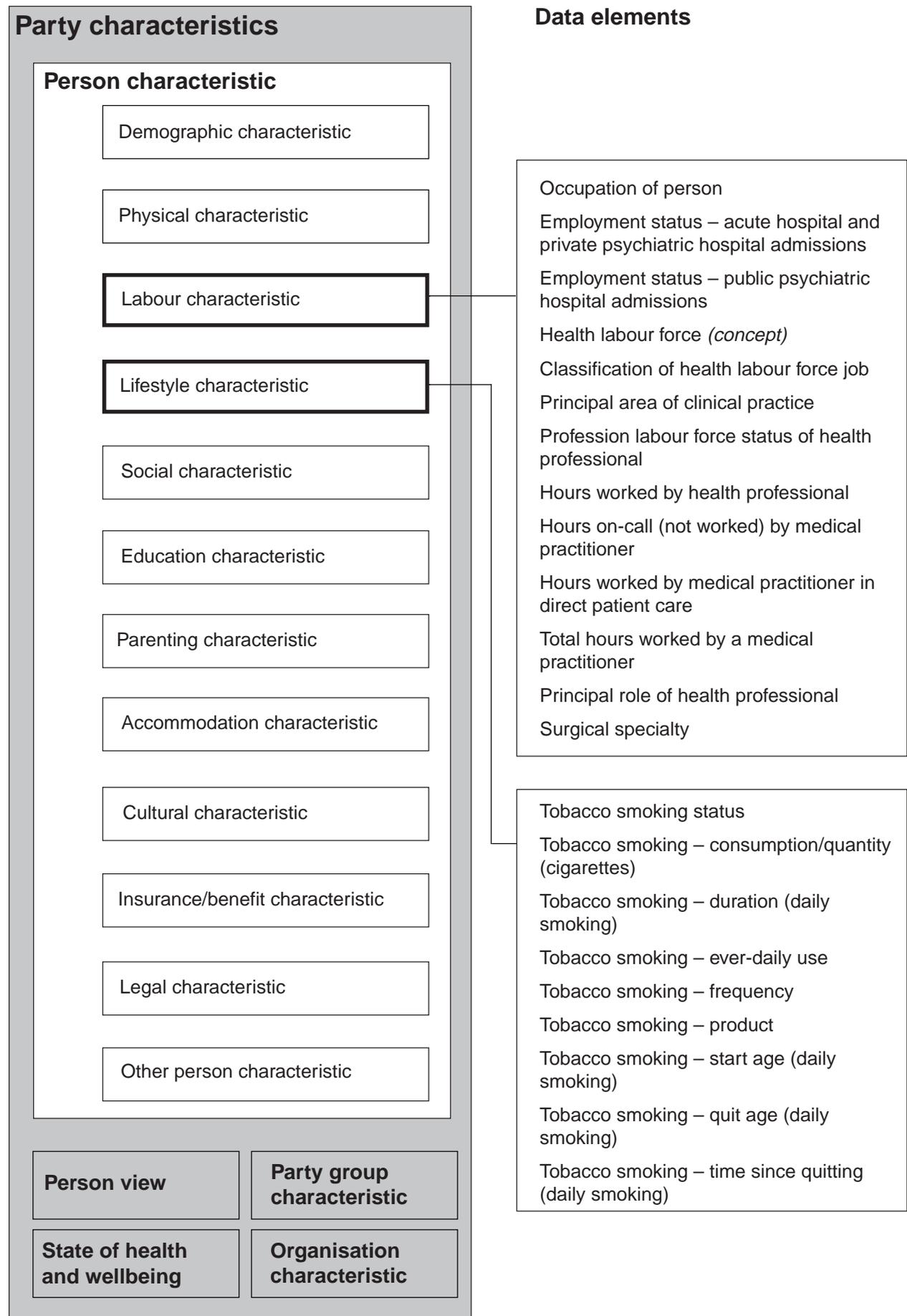
... in 5 kg categories

135 kg = Wt < 140 kg

Wt = 140 kg

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

National Health Information Model entities



Occupation of person

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000230 *Version number:* 2

Data element type: DATA ELEMENT

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

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

Guide for use:

Verification rules:

Collection methods:

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

Administrative attributes

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

Source organisation: Australian Bureau of Statistics

National minimum data sets:

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

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

Occupation of person (*continued*)

Comments (cont'd): For example:

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

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

Employment status – acute hospital and private psychiatric hospital admissions

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000395 *Version number:* 2

Data element type: DATA ELEMENT

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain: 1 Unemployed / pensioner
2 Other

Guide for use:

Verification rules:

Collection methods: In practice, this data item and current or last occupation could probably be collected with a single question, as is done in Western Australia:

Occupation?

For example:

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

However, for national reporting purposes it is preferable to distinguish these two data items logically.

Related data: relates to the data element Employment status – public psychiatric hospital admissions, version 2

supersedes previous data element Employment status, version 1

Employment status – acute hospital and private psychiatric hospital admissions (*continued*)

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

Institutional mental health care from 1/07/97 to

Comments:

Employment status – public psychiatric hospital admissions

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000317 *Version number:* 2

Data element type: DATA ELEMENT

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

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

Guide for use:

Verification rules:

Collection methods: In practice, this data item and current or last occupation could probably be collected with a single question, as is done in Western Australia:

Occupation?

For example:

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

However, for national reporting purposes it is preferable to distinguish these two data items logically.

Employment status – public psychiatric hospital admissions (continued)

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

supersedes previous data element Employment status, version 1

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

Institutional mental health care from 1/07/97 to

Comments:

Health labour force

Admin. status: CURRENT 1/07/95

Identifying and definitional attributes

Knowledgebase ID: 000061 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

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

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

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

Context: Health labour force statistics and institutional health care

Relational and representational attributes

Datatype: *Representational form:*

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

Data domain:

Guide for use:

Verification rules:

Collection methods:

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

Administrative attributes

Source document:

Source organisation: National Health Labour Force Data Working Group

National minimum data sets:

Health labourforce from 1/07/89 to

Comments:

Classification of health labour force job

Admin. status: CURRENT 1/07/95

Identifying and definitional attributes

Knowledgebase ID: 000023 *Version number:* 1

Data element type: DATA ELEMENT

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

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

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

Relational and representational attributes

Datatype: Alphanumeric *Representational form:* CODE

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

Data domain:

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

Classification of health labour force job (*continued*)

<i>Data domain (cont'd):</i>	C09	Nursing – Deputy director of nursing
	C10	Nursing – Director of nursing
	C11	Nursing – Tutor/lecturer/senior lecturer in nursing (tertiary institution)
	C12	Nursing – Associate professor/professor in nursing (tertiary institution)
	C98	Nursing – Other (specify)
	C99	Nursing – Unknown/inadequately described/not stated
	D01	Pharmacy (community pharmacist) – Sole proprietor
	D02	Pharmacy (community pharmacist) – Partner-proprietor
	D03	Pharmacy (community pharmacist) – Pharmacist-in-charge
	D04	Pharmacy (community pharmacist) – Permanent assistant
	D05	Pharmacy (community pharmacist) – Reliever, regular location
	D06	Pharmacy (community pharmacist) – Reliever, various locations
	E01	Pharmacy (Hospital/clinic pharmacist) – Director/deputy director
	E02	Pharmacy (Hospital/clinic pharmacist) – Grade III pharmacist
	E03	Pharmacy (Hospital/clinic pharmacist) – Grade II pharmacist
	E04	Pharmacy (Hospital/clinic pharmacist) – Grade I pharmacist
	E05	Pharmacy (Hospital/clinic pharmacist) – Sole pharmacist
	F01	Podiatry – Own practice (or partnership)
	F02	Podiatry – Own practice and sessional appointments elsewhere
	F03	Podiatry – Own practice and fee-for-service elsewhere
	F04	Podiatry – Own practice, sessional and fee-for-service appointments elsewhere
	F05	Podiatry – Salaried podiatrist
	F06	Podiatry – Locum, regular location
	F07	Podiatry – Locum, various locations
	F08	Podiatry – Other (specify)
	G01	Physiotherapy – Own practice (or partnership)
	G02	Physiotherapy – Own practice and sessional appointments elsewhere
	G03	Physiotherapy – Own practice and fee-for-service elsewhere
	G04	Physiotherapy – Own practice, sessional and fee-for-service appointments elsewhere
	G05	Physiotherapy – Salaried physiotherapist
	G06	Physiotherapy – Locum, regular location
	G07	Physiotherapy – Locum, various locations

Guide for use:

Verification rules:

Collection methods:

Related data:

Classification of health labour force job (*continued*)

Administrative attributes

Source document:

Source organisation: National Health Labour Force Data Working Group

National minimum data sets:

Health labourforce from 1/07/89 to

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

Principal area of clinical practice

Admin. status: CURRENT 1/07/95

Identifying and definitional attributes

Knowledgebase ID: 000135 *Version number:* 1

Data element type: DATA ELEMENT

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

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

Relational and representational attributes

Datatype: Alphanumeric *Representational form:* CODE

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

Data domain:

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

Principal area of clinical practice (*continued*)

Data domain (cont'd):	C04	Nurse labour force – operating theatre nursing
	C05	Nurse labour force – intensive care nursing
	C06	Nurse labour force – paediatric nursing
	C07	Nurse labour force – maternity and obstetric nursing
	C08	Nurse labour force – psychiatric/mental health nursing
	C09	Nurse labour force – developmental disability nursing
	C10	Nurse labour force – gerontology/geriatric nursing
	C11	Nurse labour force – accident and emergency nursing
	C12	Nurse labour force – community health nursing
	C13	Nurse labour force – child health nursing
	C14	Nurse labour force – school nursing
	C15	Nurse labour force – district/domiciliary nursing
	C16	Nurse labour force – occupational health nursing
	C17	Nurse labour force – private medical practice nursing
	C18	Nurse labour force – independent practice
	C19	Nurse labour force – independent midwifery practice
	C20	Nurse labour force – no one principal area of practice
	C98	Nurse labour force – other (specify)
	C99	Nurse labour force – unknown/inadequately described/not stated

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

Verification rules:

Collection methods:

Related data:

Administrative attributes

Source document:

Source organisation: National Health Labour Force Data Working Group

National minimum data sets:

Health labourforce from 1/07/89 to

Comments:

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

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

Profession labour force status of health professional

Admin. status: CURRENT 1/07/95

Identifying and definitional attributes

Knowledgebase ID: 000140 *Version number:* 1

Data element type: DATA ELEMENT

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

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 3 *Representational layout:* N or N.N

Data domain:

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

Profession labour force status of health professional (continued)

<i>Data domain (cont'd):</i>	5.9	Employed elsewhere, looking for work in the profession: in paid work not in the field of profession but looking for paid work/practice in the profession – seeking work (not stated)
	6.1	Unemployed, looking for work in the profession: not in paid work but looking for work in the field of profession – seeking either full-time or part-time work
	6.2	Unemployed, looking for work in the profession: not in paid work but looking for work in the field of profession – seeking full-time work
	6.3	Unemployed, looking for work in the profession: not in paid work but looking for work in the field of profession – seeking part-time work
	6.9	Unemployed, looking for work in the profession: not in paid work but looking for work in the field of profession – seeking work (not stated)
	7	Not in the labour force for the profession: not in work/practice in the profession and not looking for work/practice in the profession
	8	Not in the labour force for the profession: working overseas
	9	Unknown/not stated

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

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

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

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

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

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

Verification rules:

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

- persons working overseas although working/practising in the reference profession
- respondents working only in States other than the reference state

Profession labour force status of health professional (continued)

Collection methods (cont'd): - respondents not working in the reference profession and not looking for work in the reference profession

It also directs respondents working in the reference State and other States to respond to subsequent questions only in respect of work in the reference State. These distinctions are necessary in order to eliminate multiple counting for respondents renewing licenses to practise in more than one State.

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

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

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

Administrative attributes

Source document:

Source organisation: National Health Labour Force Data Working Group

National minimum data sets:

Health labourforce from 1/07/89 to

Comments:

Hours worked by health professional

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000313 *Version number:* 2

Data element type: DATA ELEMENT

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

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

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

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

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

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

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

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

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

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

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

Hours worked by health professional (*continued*)

Administrative attributes

Source document:

Source organisation: National Health Labour Force Data Working Group

National minimum data sets:

Health labourforce from 1/07/89 to

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

Hours on-call (not worked) by medical practitioner

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000393 *Version number:* 2

Data element type: DATA ELEMENT

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

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

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

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

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

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

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

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

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

relates to the data element Total hours worked by a medical practitioner, version 2 supersedes previous data element Hours worked, version 1

Administrative attributes

Source document:

Source organisation: National Health Labour Force Data Working Group

National minimum data sets:

Health labourforce from 1/07/89 to

Comments:

Hours worked by medical practitioner in direct patient care

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000392 *Version number:* 2

Data element type: DATA ELEMENT

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

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

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

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

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

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

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

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

relates to the data element Total hours worked by a medical practitioner, version 2 supersedes previous data element Hours worked, version 1

Administrative attributes

Source document:

Source organisation: National Health Labour Force Data Working Group

National minimum data sets:

Health labourforce from 1/07/89 to

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

Total hours worked by a medical practitioner

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000394 *Version number:* 2

Data element type: DATA ELEMENT

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

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

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

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

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

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

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

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

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

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

supersedes previous data element Hours worked, version 1

Administrative attributes

Source document:

Source organisation: National Health Labour Force Data Working Group

National minimum data sets:

Health labourforce from 1/07/89 to

Total hours worked by a medical practitioner (*continued*)

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

Principal role of health professional

Admin. status: CURRENT 1/07/95

Identifying and definitional attributes

Knowledgebase ID: 000138 *Version number:* 1

Data element type: DATA ELEMENT

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

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

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

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

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

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

Principal role of health professional (*continued*)

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

Verification rules:

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

Related data:

Administrative attributes

Source document:

Source organisation: National Health Labour Force Data Working Group

National minimum data sets:

Health labourforce from 1/07/89 to

Comments:

Surgical specialty

Admin. status: CURRENT 1/01/95

Identifying and definitional attributes

Knowledgebase ID: 000161 *Version number:* 1

Data element type: DATA ELEMENT

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

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

Guide for use:

Verification rules:

Collection methods:

Related data:

Administrative attributes

Source document:

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

National minimum data sets:

Elective surgery waiting times from 1/07/94 to

Comments: The above classifications are consistent with the Recommended Medical Specialties and Qualifications agreed by the National Specialist Qualification Advisory Committee of Australia, September 1993. Vascular surgery is a

Surgical specialty (*continued*)

Comments (cont'd): subspecialty of general surgery. The Royal Australian College of Surgeons has a training program for vascular surgeons. The specialties listed above refer to the surgical component of these specialties – ear, nose and throat surgery refers to the surgical component of the specialty otolaryngology; gynaecology refers to the gynaecological surgical component of obstetrics and gynaecology; ophthalmology refers to the surgical component of the specialty (patients awaiting argon laser phototherapy are not included).

Tobacco smoking status

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000410 *Version number:* 1

Data element type: DATA ELEMENT

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

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

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

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

- To evaluate health promotion and disease prevention programs (assessment of interventions)

- To monitor health risk factors and progress towards National Health Goals and Targets

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

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

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

Daily smoker – A person who smokes daily

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

Irregular smoker – A person who smokes less than weekly

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

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

Verification rules:

Collection methods: The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults – interviewer administered

Tobacco smoking status (*continued*)

Collection methods (cont'd): (Questions 1 and 4) and self-administered (Questions 1 and 1a) versions. The questionnaires are designed to cover persons aged 18+.

Related data: is qualified by Date of birth, version 2

Administrative attributes

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

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

National minimum data sets:

Comments: There are two other ways of categorising this information:

- Regular and irregular smokers where a regular smoker includes someone who is a daily smoker or a weekly smoker. 'Regular' smokers is the preferred category to be reported in prevalence estimates.

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

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

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

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

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

Tobacco smoking – consumption/quantity (cigarettes)

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000403 *Version number:* 1

Data element type: DATA ELEMENT

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

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

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

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

Data on quantity smoked can be used:

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

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

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

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

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

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

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

Verification rules:

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

Tobacco smoking – consumption/quantity (cigarettes) **(continued)**

Related data: is qualified by Date of birth, version 2
is qualified by Tobacco smoking – frequency, version 1
is qualified by Tobacco smoking – product, version 1

Administrative attributes

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

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

National minimum data sets:

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

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

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

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

Tobacco smoking – duration (daily smoking)

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000404 *Version number:* 1

Data element type: DERIVED DATA ELEMENT

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

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

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

Guide for use: In order to estimate duration of smoking the person's date of birth or current age should also be collected. If a person reports that they smoke daily now then duration is the difference between the start-age and the person's current age. If a person reports that they smoked daily in the past but do not smoke daily now then duration is the difference between the quit age and the start age.
Record duration of less than one year as 0.

Verification rules:

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

Related data: is qualified by Date of birth, version 2
is qualified by Tobacco smoking – ever daily use, version 1
is derived from Tobacco smoking – quit age (daily smoking), version 1
is derived from Tobacco smoking – start age (daily smoking), version 1

Administrative attributes

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

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

Tobacco smoking – duration (daily smoking) (*continued*)

National minimum data sets:

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

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

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

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

Tobacco smoking – ever daily use

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000405 *Version number:* 1

Data element type: DATA ELEMENT

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

Context: Public health and health care.

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

It can also be used:

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

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:
1 Ever-daily
2 Never-daily

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

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

Verification rules:

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

Related data: is qualified by Date of birth, version 2
is qualified by Tobacco smoking – frequency, version 1

Administrative attributes

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

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

Tobacco smoking – ever daily use (*continued*)

National minimum data sets:

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

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

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

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

Tobacco smoking – frequency

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000406 *Version number:* 1

Data element type: DATA ELEMENT

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

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

Guide for use:

Verification rules:

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

Related data: is qualified by Date of birth, version 2
is a qualifier of Tobacco smoking – consumption/quantity (cigarettes), version 1
relates to the data element Tobacco smoking – duration (daily smoking), version 1
relates to the data element Tobacco smoking – ever daily use, version 1
is used in conjunction with Tobacco smoking – product, version 1
relates to the data element Tobacco smoking – start age (daily smoking), version 1

Administrative attributes

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

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

Tobacco smoking – frequency (*continued*)

National minimum data sets:

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

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

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

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

Tobacco smoking – product

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000407 *Version number:* 1

Data element type: DATA ELEMENT

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

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

Guide for use:

Verification rules:

Collection methods: The recommended standard for collecting information about smoking the above tobacco products is the Standard Questions on the Use of Tobacco Among Adults – interviewer or self-administered versions. The questions cover persons aged 18+.

Related data: is qualified by Date of birth, version 2
is a qualifier of Tobacco smoking – consumption/quantity (cigarettes), version 1
is used in conjunction with Tobacco smoking – frequency, version 1

Administrative attributes

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

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

Tobacco smoking – product (*continued*)

National minimum data sets:

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

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

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

Tobacco smoking – start age (daily smoking)

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000409 *Version number:* 1

Data element type: DATA ELEMENT

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

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

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

Verification rules:

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

Related data: is qualified by Date of birth, version 2
is used in the derivation of Tobacco smoking – duration (daily smoking), version 1
is qualified by Tobacco smoking – ever daily use, version 1
is used in conjunction with Tobacco smoking – quit age (daily smoking), version 1

Administrative attributes

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

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

National minimum data sets:

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

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

Tobacco smoking – start age (daily smoking) (*continued*)

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

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

Tobacco smoking – quit age (daily smoking)

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000408 *Version number:* 1

Data element type: DATA ELEMENT

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

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

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

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

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

Verification rules:

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

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

Related data: is qualified by Date of birth, version 2
 is used in the derivation of Tobacco smoking – duration (daily smoking), version 1
 is used in conjunction with Tobacco smoking – start age (daily smoking), version 1
 is qualified by Tobacco smoking status, version 1
 is used in the derivation of Tobacco smoking – time since quitting (daily smoking), version 1

Tobacco smoking – quit age (daily smoking) (*continued*)

Administrative attributes

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

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

National minimum data sets:

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

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

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

Tobacco smoking – time since quitting (daily smoking)

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000411 *Version number:* 1

Data element type: DERIVED DATA ELEMENT

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

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

It is also useful in evaluating health promotion campaigns.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

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

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

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

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

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

Tobacco smoking – time since quitting (daily smoking) (continued)

Guide for use (cont'd): Where the information is about age only, time since quitting (daily use) is the difference between quit-age and age at survey.

Verification rules:

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

Related data: is qualified by Date of birth, version 2
is qualified by Tobacco smoking – ever daily use, version 1
is derived from Tobacco smoking – quit age (daily smoking), version 1

Administrative attributes

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

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

National minimum data sets:

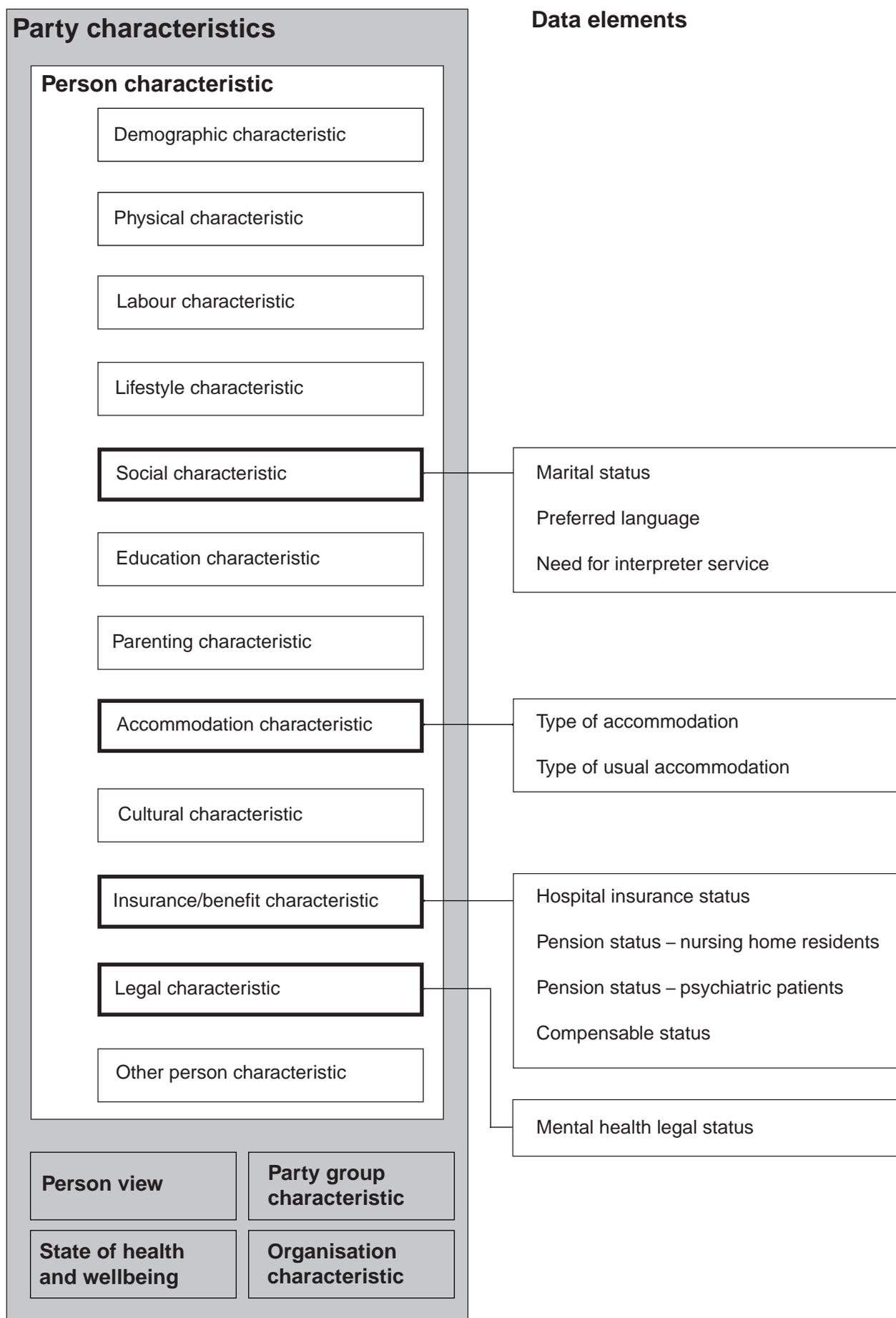
Comments: Where this information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

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

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

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

National Health Information Model entities



Marital status

Admin. status: CURRENT 1/07/94

Identifying and definitional attributes

Knowledgebase ID: 000089 *Version number:* 2

Data element type: DATA ELEMENT

Definition: Current marital status of the person.

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

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

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

Verification rules:

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

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

Administrative attributes

Source document: ABS Directory of concepts and standards for social, labour and demographic statistics, 1993

Source organisation: Australian Bureau of Statistics

National minimum data sets:

Institutional mental health care from 1/07/97 to

Marital status (*continued*)

Comments:

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

- registered marital status-defined as whether a person has, or has had, a legally registered marriage;

- social marital status-based on a persons living arrangements (including de-facto marriages), as reported by the person.

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

Preferred language

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000132 *Version number:* 2

Data element type: DATA ELEMENT

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

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

Preferred language (*continued*)

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

Preferred language (*continued*)

<i>Data domain (cont'd)</i>	71	Tamil
	72	Telugu
	73	Teochew
	74	Thai
	75	Timorese
	76	Tiwi
	77	Tongan
	78	Turkish
	79	Ukranian
	80	Urdu
	81	Vietnamese
	82	Walmajarri (Walmadjari)
	83	Warlpiri
	84	Welsh
	85	Wik-Mungkan
	86	Yiddish
	95	Other languages, nfd
	96	Inadequately described
	97	Non verbal, so described (including sign languages eg Auslan, Makaton)
	98	Not stated

Guide for use:

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

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

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

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

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

Verification rules:**Collection methods:**

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

Related data:

supersedes previous data element Preferred language, version 1

Administrative attributes**Source document:**

Australian Standard Classification of Languages, (ASCL)
Australian Bureau of Statistics, Catalogue number 1267.0

Preferred language (*continued*)

Source organisation: National Health Data Committee, Australian Bureau of Statistics

National minimum data sets:

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

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

Need for interpreter service

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000100 *Version number:* 1

Data element type: DATA ELEMENT

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain: 0 Interpreter not needed
1 Interpreter needed

Guide for use:

Verification rules:

Collection methods:

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

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

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

Type of accommodation

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000173 *Version number:* 2

Data element type: DATA ELEMENT

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

Context: Institutional health care: permits analysis of the usual residential accommodation type of people prior to admission to institutional health care.

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

Relational and representational attributes

Datatype: Alphabetic *Representational form:* CODE

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

Data domain:

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

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

Type of accommodation (*continued*)

Guide for use (cont'd): 3 – Includes nursing home beds in acute care hospitals.

4 – Includes alcohol/other drug treatment units in psychiatric hospitals.

5 – Specialised mental health community-based residential support services are defined as community-based residential supported accommodation specifically targeted at people with psychiatric disabilities which provides 24-hour support/rehabilitation on a residential basis.

6 – Domestic-scale supported living facilities include group homes for people with disabilities, cluster apartments where a support worker lives on-site, community residential apartments (except mental health), congregate care arrangements. Support is provided by staff on either a live-in or rostered basis, and they may or may not have 24-hour supervision and care.

10 – Includes other supported accommodation facilities such as hostels for people with disabilities and Residential Services/Facilities (Victoria and South Australia only). These facilities provide board and lodging and rostered care workers provide client support services.

Verification rules:

Collection methods:

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

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional mental health care from 1/07/99 to

Comments: The changes made to this data element are in accordance with the requirements of the National Mental Health Information Strategy Committee and take into consideration corresponding definitions in other data dictionaries (e.g. HACC Data Dictionary Version 1 and National Community Services Data Dictionary Version 1).

In December 1998, the National Health Information Management Group decided that this data element would be implemented from 1 July 1999 in the Institutional mental health NMDS. However, to assist with the transition to the new reporting requirements for the Institutional mental health NMDS establishments may report either this new version of the data element or the previous version (Type of usual accommodation, version 1) with the expectation that agencies will make their best efforts to report against the new version of this data element (Type of accommodation, version 2) from 1 July 1999.

Type of usual accommodation

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000173 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The type of physical accommodation the person lived in prior to admission.

Context: Institutional health care: permits analysis of the prior residential accommodation type of people admitted to nursing homes or other institutional care.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

1	House or flat
2	Independent unit as part of retirement village or similar
3	Hostel or hostel type accommodation
4	Psychiatric hospital
5	Acute hospital
6	Other accommodation
7	No usual residence

Guide for use:

Verification rules:

Collection methods: The above classifications have been based on Question 16 of Form NH5. This item is not available for New South Wales State nursing homes.

As this data item includes only details of physical accommodation before admission it was decided to have details of the relational basis of accommodation before admission collected as a separate data element (see data element 'Source of referral').

The Commonwealth Department of Health and Aged Care has introduced a new Aged Care Application and Approval form which replaces the NH5. In the light of this and other changes to the nursing home and hostel sector, this data element will be reviewed during 1999.

Related data: is an alternative to Type of accommodation, version 2

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

Institutional mental health care from 1/07/97 to

Type of usual accommodation (*continued*)

Comments: In December 1998, the National Health Information Management Group decided that a new version of this data element (named Type of accommodation, version 2) would be implemented from 1 July 1999 in the Institutional mental health NMDS. However, to assist with the transition to the new reporting requirements for the Institutional mental health NMDS establishments may report either the new version of the data element (Type of accommodation, version 2) or this data element with the expectation that agencies will make their best efforts to report against the new version of this data element (Type of accommodation, version 2) from 1 July 1999.

Hospital insurance status

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000075 *Version number:* 3

Data element type: DATA ELEMENT

Definition: Hospital insurance under one of the following categories:

1. Registered insurance – hospital insurance with a health insurance fund registered under the National Health Act 1953 (C'wlth);
2. General insurance – hospital insurance with a general insurance company under a guaranteed renewable policy providing benefits similar to those available under registered insurance.

No hospital insurance or benefits coverage under the above.

Context: To assist in analysis of utilisation and health care financing

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

1	Hospital insurance
2	No hospital insurance
9	Unknown

Guide for use: Persons covered by insurance for benefits of ancillary services only are included in 2. no hospital insurance.

The 'unknown' category should not be used in primary collections but can be used to record unknown insurance status in databases.

This item is to determine whether the patient has hospital insurance, not their method of payment for the episode of care.

Verification rules:

Collection methods:

Related data: is used in conjunction with Patient accommodation eligibility status, version 2
supersedes previous data element Insurance status, version 2

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Institutional mental health care from 1/07/97 to

Hospital insurance status (*continued*)

Comments:

Insurance status was reviewed and modified to reflect changes to new private health insurance arrangements under the Health Legislation (Private Health Insurance Reform) Amendment Act 1995.

Employee health benefits schemes became illegal with the implementation of Schedule 2 of the private health insurance reforms, effective on 1 October 1995.

Under Schedule 4 of the private health insurance reforms, on 1 July 1997, the definition of the 'basic private table' or 'basic table', and 'supplementary hospital table' and any references to these definitions was omitted from the National Health Act 1953. All hospital tables offered by registered private health insurers since 29 May 1995 have been referred to as 'Applicable Benefits Arrangements' and marketed under the insurer's own product name.

Pension status – nursing home residents

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000383 *Version number:* 2

Data element type: DATA ELEMENT

Definition: Whether or not a person is in receipt of a pension and the nature of that pension (note that this does not mean the pension is necessarily the recipient's main source of income).

Context: This data element is likely to be a factor in determining equity of services and could be a surrogate indicator of income.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

1	Aged pension – full pension without rent assistance
2	Aged pension – full pension plus rent assistance
3	Repatriation pension
4	Disability support pension
5	Other pension or benefit
6	No pension

Guide for use:

Verification rules:

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

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

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

Comments: This data element will be reviewed during 1999.

Pension status – psychiatric patients

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000121 *Version number:* 2

Data element type: DATA ELEMENT

Definition: Whether or not a person is in receipt of a pension or social security benefit and the nature of that pension or benefit (note that this does not mean the pension / benefit is necessarily the recipient's main source of income)

Context: This item is a factor in determining equity of services, community needs, a surrogate indicator of income, and useful in analysis of total resource allocation to psychiatric care in Australia.

A substantial proportion of the consumers of public psychiatric services are people whose sole or major source of income is some form of pension or Commonwealth benefit.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

1	Aged pension
2	Repatriation pension
3	Invalid pension
4	Unemployment benefit
5	Sickness benefit
6	Other pension / benefit

Guide for use:

Verification rules:

Collection methods:

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

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

Institutional mental health care from 1/07/97 to

Comments:

Compensable status

Admin. status: CURRENT 1/07/93

Identifying and definitional attributes

Knowledgebase ID: 000026 *Version number:* 2

Data element type: DATA ELEMENT

Definition: Any person who is entitled to the payment of, or who has been paid compensation for, damages or other benefits (including a payment in settlement of a claim for compensation, damages or other benefits) in respect of the injury, illness or disease for which he or she is receiving care and treatment, is classified as a compensable patient.

Context: To assist in analyses of utilisation and health care funding.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:
1 Compensable
2 Non-compensable

Guide for use: This definition excludes entitled beneficiaries (Veterans' Affairs) and Defence Force personnel and persons covered by the Motor Accident Compensation Scheme, Northern Territory.

Verification rules:

Collection methods: Compensable status is to be recorded on the person's separation from hospital. It is recognised that the compensable status of a patient may change during the course of the hospital stay, and it is therefore recommended that this data element reflect the status of the patient at separation.

Related data: is used in conjunction with Patient accommodation eligibility status, version 2 supersedes previous data element Compensable status, version 1

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Institutional mental health care from 1/07/97 to

Comments:

Mental health legal status

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000092 *Version number:* 4

Data element type: DATA ELEMENT

Definition: Whether a person is treated on an involuntary basis under the relevant State or Territory mental health legislation, at any time during an episode of care for an admitted patient or treatment of a patient/client by a community based service during a reporting period.

Involuntary patients are persons who are detained in hospital or compulsorily treated in the community under mental health legislation for the purpose of assessment or provision of appropriate treatment or care.

Context: Mental health care: this data element is required to monitor trends in the use of compulsory treatment provisions under State and Territory mental health legislation by Australian hospitals and community health care facilities, including 24-hour community based residential services. For those hospitals and community mental health services which provide psychiatric treatment to involuntary patients, mental health legal status information is an essential data element within local record systems.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:
1 Involuntary patient
2 Voluntary patient

Guide for use: Approval is required under the State or Territory mental health legislation in order to detain patients for the provision of mental health care or for patients to be treated compulsorily in the community. Code 1 involuntary status should only be used by facilities which are approved for this purpose. While each State and Territory mental health legislation differs in the number of categories of involuntary patient that are recognised, and the specific titles and legal conditions applying to each type, the legal status categories which provide for compulsory detention or compulsory treatment of the patient can be readily differentiated within each jurisdiction. These include special categories for forensic patients who are charged with or convicted of some form of criminal activity.

Each State/Territory health authority should identify which sections of their mental health legislation provide for detention or compulsory treatment of the patient and code these as involuntary status.

The mental health legal status of admitted patients treated within approved

Mental health legal status (*continued*)

Guide for use (cont'd): hospitals may change many times throughout the episode of care. Patients may be admitted to hospital on an involuntary basis and subsequently be changed to voluntary status; some patients are admitted as voluntary but are transferred to involuntary status during the hospital stay. Multiple changes between voluntary and involuntary status during an episode of care in hospital or treatment in the community may occur depending on the patient's clinical condition and his/her capacity to consent to treatment.

Verification rules:

- Collection methods:**
- 1 Admitted patients: to be collected if the patient is involuntary at any time during the episode of care.
 - 2 Patients in 24-hour staffed community-based residential services: to be collected if the patient is involuntary at any time during the stay in the residence.
 - 3 Non-admitted patients: to be collected if the patient is involuntary at any time during a specified collection period.

Related data: supersedes previous data element Mental health legal status, version 3

Administrative attributes

Source document:

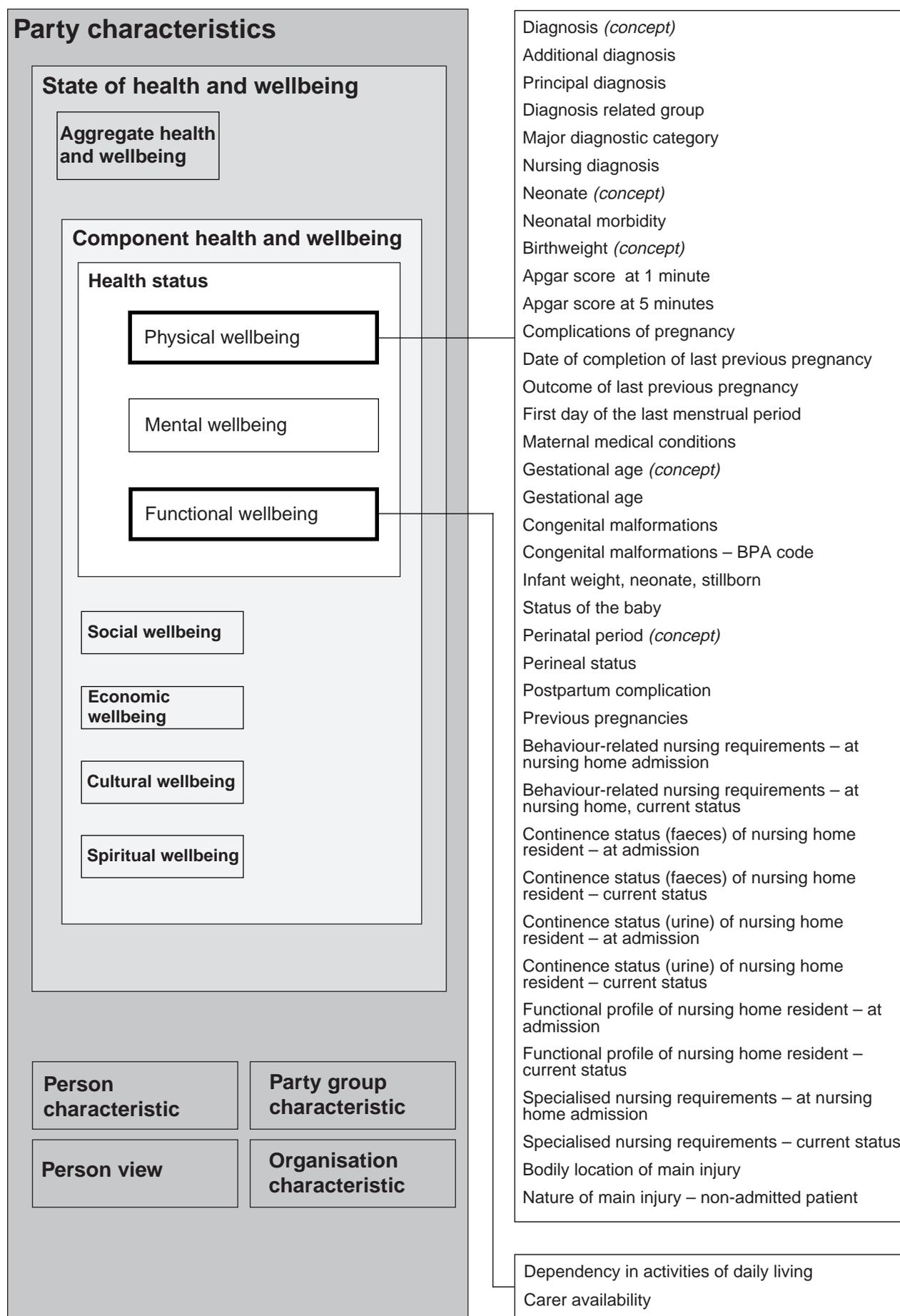
Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care	from 1/07/89 to
Institutional mental health care	from 1/07/99 to
Community mental health care	from 1/07/2000 to

Comments:

National Health Information Model entities



Diagnosis

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000398 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

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

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

Relational and representational attributes

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, version 2
 relates to the data element Maternal medical conditions, version 2
 relates to the data element External cause – admitted patient, version 4
 relates to the data element Principal diagnosis, version 3
 relates to the data element Complication of labour and delivery, version 2
 relates to the data element Postpartum complication, version 2
 relates to the data element Neonatal morbidity, version 2
 relates to the data element Congenital malformations, version 2
 relates to the data element Additional diagnosis, 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:

International Statistical Classification of Diseases and Related Health Problems – Tenth Revision – Australian Modification (1998) (ICD-10-AM)

Diagnosis (*continued*)

Comments (cont'd): British Paediatric Association Classification of Diseases (1979)
North America Nursing Diagnosis Association (NANDA)
International Classification of Primary Care (1987)
International Classification of Impairments, Disabilities and Handicaps (1980)
International Classification of Impairments, Disabilities and Handicaps Beta/1
draft revised classification (1997).

Additional diagnosis

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000005 *Version number:* 4

Data element type: DATA ELEMENT

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

Context: 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 Refined 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 ICD-10-AM Australian Coding Standards. An unlimited number of diagnosis and procedure codes should be able to be collected in hospital morbidity systems. Where this is not possible, a minimum of 20 codes should be able to be collected.

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.

The first edition of ICD-10-AM, the Australian modification of ICD-10, was published by the National Centre for Classification in Health and implemented from July 1998. New South Wales, Victoria, the Australian Capital Territory and the Northern Territory implemented ICD-10-AM from 1 July 1998. Other States will implement this classification from 1 July 1999.

Verification rules:

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

Related data: supersedes previous 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, version 3

Additional diagnosis (*continued*)

Administrative attributes

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

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

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 1/07/2000 to

Palliative care from 1/07/2000 to

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

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

Principal diagnosis

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000136 *Version number:* 3

Data element type: DATA ELEMENT

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

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

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

Relational and representational attributes

Datatype: Alphanumeric *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. Each episode of admitted patient care must have a principal diagnosis and may have additional diagnoses.

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

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

Verification rules: As a minimum requirement the Principal diagnosis code must be a valid code from 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 Refined Diagnosis Related Groups, Version 4. A list of these diagnosis codes is available from the Acute and Coordinated Care Branch, Health Services Division, Department of Health and Aged Care.

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

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

Principal diagnosis (*continued*)

Collection methods (cont'd): 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 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 – human intent, version 4
relates to the data element External cause – admitted patient, version 4
relates to the data element Additional diagnosis, version 4
relates to the data element External cause – non-admitted patient, version 4
relates to the data element Procedure, version 5

Administrative attributes

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

Source organisation: National Health Data Committee, National 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 1/07/2000 to
Palliative care	from 1/07/2000 to

Comments: The National Centre for Classification in Health advises the National Health Data Committee on relevant changes to the ICD-10-AM. New South Wales, Victoria, the Australian Capital Territory and the Northern Territory implemented ICD-10-AM from 1 July 1998. Other States implemented this classification from 1 July 1999.

Diagnosis related group

Admin. status: CURRENT 1/07/93

Identifying and definitional attributes

Knowledgebase ID: 000042 *Version number:* 1

Data element type: DATA ELEMENT

Definition: A patient classification scheme which provides a means of relating the number and types of patients treated in a hospital to the resources required by the hospital.

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

Relational and representational attributes

Datatype: Alphanumeric *Representational form:* CODE

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

Data domain: Australian Refined Diagnosis Related Groups, 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 Mode of separation, version 2
- is derived from Intended length of hospital stay, version 1
- is derived from Infant weight, neonate, stillborn, version 3
- is derived from Principal diagnosis, version 3
- is derived from Additional diagnosis, version 4
- is derived from Procedure, version 5
- is derived from Separation date, version 5
- is derived from Admission date, version 4

Administrative attributes

Source document:

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

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 Australian Refined Diagnosis Related Group is derived from a range of data collected on admitted patients, including diagnosis and procedure information, classified using ICD-10-AM. The data elements required are described in Related data elements.

Major diagnostic category

Admin. status: CURRENT 1/07/93

Identifying and definitional attributes

Knowledgebase ID: 000088 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Major Diagnostic Categories are 23 mutually exclusive categories into which all possible principal diagnoses fall. The diagnoses in each category correspond to a single body system or aetiology, broadly reflecting the speciality providing care. Each category is partitioned according to whether or not a surgical procedure was performed. This preliminary partitioning into Major Diagnostic Categories occurs before a Diagnosis Related Group is assigned. The Australian Refined Diagnosis Related Groups departs from the use of principal diagnosis as the initial variable in the assignment of some groups. A hierarchy of all exceptions to the principal diagnosis-based assignment to a Major Diagnostic Category has been created. As a consequence, certain Australian Refined Diagnosis Related Groups are not unique to a Major Diagnostic Category. This requires both a Major Diagnostic Category and an Australian Refined Diagnosis Related Group to be generated per patient.

Context: Institutional health care: the generation of a Major Diagnostic Category to accompany each Australian Refined 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 Refined Diagnosis Related Groups

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 4
is used in the derivation of Diagnosis related group, version 1
is derived from Infant weight, neonate, stillborn, version 3
is derived from Principal diagnosis, version 3
is derived from Additional diagnosis, version 4

Administrative attributes

Source document:

Source organisation: Department of Health and Aged Care, Acute and Co-ordinated Care 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 Refined Diagnosis Related Groups (as defined in the data element Diagnosis related group) by the Acute and Co-ordinated Care Branch, Commonwealth Department of Health and Aged Care. Due to the modifications in the Diagnosis Related Group logic for the Australian Refined Diagnosis Related Groups, it is necessary to generate the Major Diagnostic Category to accompany each Diagnosis Related Group. The construction of the pre-Major Diagnostic Category logic means Diagnosis Related Groups are no longer unique. Certain pre-Major Diagnostic Category Diagnosis Related Groups may occur in more than one of the 23 Major Diagnostic Categories. For example, liver transplant DRG 005, may occur in any of the Major Diagnostic Categories according to the principal diagnosis. AR-DRGs 950-954 (excluding AR-DRG 952 in most cases) also require the allocation of a Major Diagnostic Category according to the principal diagnosis.

Nursing diagnosis

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000110 *Version number:* 2

Data element type: DATA ELEMENT

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

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

Relational and representational attributes

Datatype: Alphanumeric *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 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.

Nursing diagnosis (*continued*)

Related data: supersedes 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

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.

Neonate

Admin. status: CURRENT 1/07/95

Identifying and definitional attributes

Knowledgebase ID: 000103 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

Definition: A live birth who is less than 28 days old.

Context: Perinatal

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 Health Data Committee, National Perinatal Data Development Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Perinatal from 1/07/97 to

Comments: The neonatal period is exactly four weeks or 28 completed days, commencing on the date of birth (day 0) and ending on the completion of day 27. For example, a baby born on 1 October remains a neonate until completion of the four weeks on 28 October and is no longer a neonate on 29 October.

Neonatal morbidity

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 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 implemented ICD-10-AM from 1 July 1998. Other States will implement ICD-10-AM from 1 July 1999.

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

Collection methods:

Related data: supersedes previous data element Neonatal morbidity – ICD-9-CM code, version 1
is used in conjunction with Congenital malformations – BPA code, version 1
is used in conjunction with Congenital malformations, version 2

Administrative attributes

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

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Comments:

Birthweight

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000021 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

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

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

Context: Perinatal

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 Development Committee

National minimum data sets:

Perinatal 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.

Apgar score at 1 minute

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000344 *Version number:* 1

Data element type: DATA ELEMENT

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

Context: Perinatal 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 Development Committee

National minimum data sets:

Comments:

Apgar score at 5 minutes

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000345 *Version number:* 1

Data element type: DATA ELEMENT

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

Context: Perinatal 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 Development Committee

National minimum data sets:

Comments:

Complications of pregnancy

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000028 *Version number:* 2

Data element type: DATA ELEMENT

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

Context: Perinatal 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 implemented ICD-10-AM from 1 July 1998. Other States will implement ICD-10-AM from 1 July 1999.

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

Collection methods:

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

is used in conjunction with Maternal medical conditions, version 2

Administrative attributes

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

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Comments:

Date of completion of last previous pregnancy

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000037 *Version number:* 1

Data element type: DATA ELEMENT

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

Context: Perinatal 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 Development 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.

Outcome of last previous pregnancy

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000114 *Version number:* 1

Data element type: DATA ELEMENT

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

Context: Perinatal 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 Development Committee

National minimum data sets:

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

First day of the last menstrual period

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000056 *Version number:* 1

Data element type: DATA ELEMENT

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

Context: Perinatal 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 Development Committee

National minimum data sets:

Perinatal from 1/07/97 to

Comments:

Maternal medical conditions

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000090 *Version number:* 2

Data element type: DATA ELEMENT

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

Context: Perinatal 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 implemented ICD-10-AM from 1 July 1998. Other States will implement ICD-10-AM from 1 July 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, 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 Development Committee

National minimum data sets:

Comments:

Gestational age

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000059 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

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

WHO identifies the following categories:

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

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

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

Context: Perinatal

Relational and representational attributes

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 Development Committee

National minimum data sets:

Perinatal from 1/07/97 to

Comments:

Gestational age

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000060 *Version number:* 1

Data element type: DATA ELEMENT

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

Context: Perinatal 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.

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.

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 Development Committee

National minimum data sets:

Perinatal from 1/07/97 to

Comments:

Congenital malformations

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000030 *Version number:* 2

Data element type: DATA ELEMENT

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

Context: 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 implemented ICD-10-AM from 1 July 1998. Other States will implement ICD-10-AM from 1 July 1999.

Verification rules:

Collection methods:

Related data: supersedes previous data element Congenital malformations – ICD-9-CM code, version 1

is used in conjunction with Neonatal morbidity, version 2

Administrative attributes

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

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Comments:

Congenital malformations – BPA code

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000029 *Version number:* 1

Data element type: DATA ELEMENT

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

Context: Perinatal 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-10-AM is the preferred method of coding admitted patients. For perinatal data collection, the use of BPA is preferred as this is more detailed.

Verification rules:

Collection methods:

Related data: is used in conjunction with Neonatal morbidity, version 2

Administrative attributes

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

Source organisation: National Perinatal Data Development Committee

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.

Infant weight, neonate, stillborn

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000010 *Version number:* 3

Data element type: DATA ELEMENT

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

Context: Weight is an important indicator of pregnancy outcome, is a major risk factor for neonatal morbidity and mortality and is required to analyse perinatal services for high-risk infants.
This item is required to generate Australian Refined 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: For live births, birthweight should preferably be measured within the first hour of life before significant postnatal weight loss has occurred. While statistical tabulations include 500 g groupings for birthweight, weights should not be recorded in those groupings. The actual weight should be recorded to the degree of accuracy to which it is measured.

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

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

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

Collection methods:

Related data: is used in the derivation of Diagnosis related group, version 1
supersedes previous data element Stillborn, live born baby, infant weight, version 2

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Perinatal from 1/07/97 to

Comments:

Status of the baby

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 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 Development Committee

National minimum data sets:

Perinatal from 1/07/97 to

Comments:

Perinatal period

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000124 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

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

Context: Perinatal

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 Development Committee

National minimum data sets:

Perinatal 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

Knowledgebase ID: 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 Development Committee

National minimum data sets:

Comments:

Postpartum complication

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000131 *Version number:* 2

Data element type: DATA ELEMENT

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

Context: Perinatal 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 implemented ICD-10-AM from 1 July 1998. Other States will implement ICD-10-AM from 1 July 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, 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 Development 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

Knowledgebase ID: 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

Previous pregnancies (*continued*)

Administrative attributes

Source document:

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Comments:

Behaviour-related nursing requirements – at nursing home admission

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000018 *Version number:* 1

Data element type: DATA ELEMENT

Definition: A measure of the additional nursing and personal care time for nursing home residents at the time of admission required for nursing home residents resulting from certain behaviour (normally arising from the resident's mental state) such as disorientation, confusion, aggression, severe agitation or extreme anxiety, wandering and noisiness, and disruptive or self-destructive behaviour. Note that this is not intended to cover the routine or normal levels of social and emotional support.

Context: Nursing home statistics: along with functional profile, continence and specialised nursing procedures, behaviour constitutes one of the key indicators of dependency and disability for nursing home residents and serves to supplement Resident Classification Instrument level of dependency which is also in the dictionary.

Relational and representational attributes

Datatype: Alphabetic *Representational form:* CODE

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

Data domain:

A	For additional attention
B	Less than 0.5 hours of direct individual attention per day
C	From 0.5 to 1.5 hours of individual attention per day or attention for two or more hours at least once a week on an episodic basis
D	More than 1.5 hours of individual attention per day

Guide for use:

Verification rules:

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

Related data:

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

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

Behaviour-related nursing requirements – at nursing home, current status

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000374 *Version number:* 1

Data element type: DATA ELEMENT

Definition: A measure of the current status of additional nursing and personal care time required for nursing home residents resulting from certain behaviour (normally arising from the resident's mental state) such as disorientation, confusion, aggression, severe agitation or extreme anxiety, wandering and noisiness, and disruptive or self-destructive behaviour. Note that this is not intended to cover the routine or normal levels of social and emotional support.

Context: Nursing home statistics: along with functional profile, continence and specialised nursing procedures, behaviour constitutes one of the key indicators of dependency and disability for nursing home residents and serves to supplement Resident Classification Instrument level of dependency which is also in the dictionary.

Relational and representational attributes

Datatype: Alphabetic *Representational form:* CODE

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

Data domain:

A	For additional attention
B	Less than 0.5 hours of direct individual attention per day
C	From 0.5 to 1.5 hours of individual attention per day or attention for two or more hours at least once a week on an episodic basis
D	More than 1.5 hours of individual attention per day

Guide for use:

Verification rules:

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

Related data:

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

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

Continence status (faeces) of nursing home resident – at admission

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000033 *Version number:* 2

Data element type: DATA ELEMENT

Definition: A measure of the level of incontinence (faeces) of a person at the time of admission to a nursing home in terms of the frequency with which the resident is incontinent.

Context: Nursing home statistics: along with continence, behaviour and specialised nursing procedures, functional profile constitutes one of the key indicators of dependency and disability for nursing home residents and serves to supplement the Resident Classification Instrument level of dependency.

Relational and representational attributes

Datatype: Alphanumeric *Representational form:* CODE

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

Data domain:

A	Continent
B	Incontinent, but not daily
C	Incontinent, occurring once daily
D	Incontinent, occurring regularly more than once daily

Guide for use:

Verification rules:

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

Related data: supersedes previous data element Continence status at admission, version 1

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

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

Contenance status (faeces) of nursing home resident – current status

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000034 *Version number:* 2

Data element type: DATA ELEMENT

Definition: A measure of the nursing home resident's current level of incontinence (faeces) in terms of the frequency with which the resident is incontinent.

Context: Nursing home statistics: along with continence, behaviour and specialised nursing procedures, functional profile constitutes one of the key indicators of dependency and disability for nursing home residents and serves to supplement the Resident Classification Instrument level of dependency.

Relational and representational attributes

Datatype: Alphanumeric *Representational form:* CODE

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

Data domain:

A	Continent
B	Incontinent, but not daily
C	Incontinent, occurring once daily
D	Incontinent, occurring regularly more than once daily

Guide for use:

Verification rules:

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

Related data:

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

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

Continence status (urine) of nursing home resident – at admission

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000375 *Version number:* 2

Data element type: DATA ELEMENT

Definition: A measure of the level of incontinence (urine) of a person at the time of admission to a nursing home in terms of the frequency with which the resident is incontinent.

Context: Nursing home statistics: along with continence, behaviour and specialised nursing procedures, functional profile constitutes one of the key indicators of dependency and disability for nursing home residents and serves to supplement the Resident Classification Instrument level of dependency.

Relational and representational attributes

Datatype: Alphanumeric *Representational form:* CODE

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

Data domain:

A	Continent
B	Incontinent, but not daily
C	Incontinent, occurring once daily
D	Incontinent, occurring regularly more than once daily

Guide for use:

Verification rules:

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

Related data:

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

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

Continence status (urine) of nursing home resident – current status

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000376 *Version number:* 2

Data element type: DATA ELEMENT

Definition: A measure of the nursing home resident's current level of incontinence (urine) in terms of the frequency with which the resident is incontinent.

Context: Nursing home statistics: along with continence, behaviour and specialised nursing procedures, functional profile constitutes one of the key indicators of dependency and disability for nursing home residents and serves to supplement the Resident Classification Instrument level of dependency.

Relational and representational attributes

Datatype: Alphabetic *Representational form:* CODE

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

Data domain:

A	Continent
B	Incontinent, but not daily
C	Incontinent, occurring once daily
D	Incontinent, occurring regularly more than once daily

Guide for use:

Verification rules:

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

Related data:

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

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

Functional profile of nursing home resident – at admission

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000057 *Version number:* 1

Data element type: DATA ELEMENT

Definition: A measure of the extent to which a person requires assistance in relation to a range of normal activities at the time of admission to a nursing home.

Context: Nursing home statistics: along with continence, behaviour and specialised nursing procedures, functional profile constitutes one of the key indicators of dependency and disability for nursing home residents and serves to supplement the Resident Classification Instrument level of dependency.

Relational and representational attributes

Datatype: Alphanumeric *Representational form:* CODE

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

Data domain: Code comprising alphabetic (A-D) and numeric value (1-5)

- 1 Transferring to / from bed / chair / walking aid
- 2 Mobility
- 3 Bath / shower
- 4 Dressing / undressing (including fitting of artificial limbs and appliances)
- 5 Eating (fluids and solid food)
- A Requires no assistance
- B Requires observation / encouragement but no hands-on assistance
- C Requires some hands-on assistance
- D Requires full assistance

Guide for use:

Verification rules:

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

Related data:

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

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

Functional profile of nursing home resident – current status

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000058 *Version number:* 1

Data element type: DATA ELEMENT

Definition: A measure of the extent to which a nursing home resident requires assistance in relation to a range of normal activities.

Context: Nursing home statistics: along with continence, behaviour and specialised nursing procedures, functional profile constitutes one of the key indicators of dependency and disability for nursing home residents and serves to supplement the Resident Classification Instrument level of dependency.

Relational and representational attributes

Datatype: Alphanumeric *Representational form:* CODE

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

Data domain: Code comprising alphabetic (A-D) and numeric value (1-5)

- 1 Transferring to / from bed / chair / walking aid
- 2 Mobility
- 3 Bath / shower
- 4 Dressing / undressing (including fitting of artificial limbs and appliances)
- 5 Eating (fluids and solid food)
- A Requires no assistance
- B Requires observation / encouragement but no hands-on assistance
- C Requires some hands-on assistance
- D Requires full assistance

Guide for use:

Verification rules:

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

Related data:

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

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

Specialised nursing requirements – at nursing home admission

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000153 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The additional nursing and personal care attention required at the time of admission to a nursing home as a result of the resident needing specialised nursing procedures, such as colostomy/catheter care, unstable diabetes management. This is not intended to include time spent in relation to routine nursing procedures.

Context: Nursing home statistics: along with functional profile, continence and behaviour, specialised nursing procedures constitute one of the key indicators of dependency and disability for nursing home residents and serve to supplement the Resident Classification Instrument dependency level. The data item has been based on the Resident Classification Instrument rather than the NH5 because the NH5 only provides the status at or before admission and does not provide current status.

Relational and representational attributes

Datatype: Alphabetic *Representational form:* CODE

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

Data domain:

A	No specialised nursing procedures
B	Less than 0.5 hours of attention per day
C	From 0.5 to 1.5 hours of attention per day
D	More than 1 hour of attention per day

Guide for use:

Verification rules:

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

Related data:

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

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

Specialised nursing requirements – current status

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000154 *Version number:* 1

Data element type: DATA ELEMENT

Definition: A nursing home resident's current requirement for additional nursing and personal care attention as a result of the resident needing specialised nursing procedures, such as colostomy/catheter care, unstable diabetes management. This is not intended to include time spent in relation to routine nursing procedures.

Context: Nursing home statistics: along with functional profile, continence and behaviour, specialised nursing procedures constitute one of the key indicators of dependency and disability for nursing home residents and serve to supplement the Resident Classification Instrument dependency level. The data item has been based on the Resident Classification Instrument rather than the NH5 because the NH5 only provides the status at or before admission and does not provide current status.

Relational and representational attributes

Datatype: Alphabetic *Representational form:* CODE

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

Data domain:

A	No specialised nursing procedures
B	Less than 0.5 hours of attention per day
C	From 0.5 to 1.5 hours of attention per day
D	More than 1 hour of attention per day

Guide for use:

Verification rules:

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

Related data:

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

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

Bodily location of main injury

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000086 *Version number:* 1

Data element type: DATA ELEMENT

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

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

Relational and representational attributes

Datatype: Numeric *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 implemented ICD-10-AM from 1 July 1998. Other States will implement ICD-10-AM from 1 July 1999.

Bodily location of main injury (*continued*)

Guide for use (cont'd): 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 data: is used in conjunction with Nature of main injury – non-admitted patient, version 1

Administrative attributes

Source document:

Source organisation: Australian Institute of Health and Welfare 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-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.

Nature of main injury – non-admitted patient

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000087 *Version number:* 1

Data element type: DATA ELEMENT

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

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

Relational and representational attributes

Datatype: Numeric *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])

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

Data domain (cont'd):	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 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 implemented ICD-10-AM from 1 July 1998. Other States will implement ICD-10-AM from 1 July 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: Australian Institute of Health and Welfare National Injury Surveillance Unit and National Data Standards for Injury Surveillance Advisory Group

National minimum data sets:

Injury surveillance from 1/07/89 to

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

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.

Dependency in activities of daily living

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000309 *Version number:* 2

Data element type: DATA ELEMENT

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

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

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

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

Relational and representational attributes

Datatype: Numeric *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.

Dependency in activities of daily living (*continued*)

Guide for use (cont'd): All items must be completed

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.

Carer availability

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000022 *Version number:* 2

Data element type: DATA ELEMENT

Definition: A record of whether a person has been identified, such as a family member, friend or neighbour as providing regular on-going care, or assistance which is not linked to a formal service.

Context: The availability of informal care at home is often a determinant of a person's ability to remain in home care, especially if they are highly dependent. It is also an indicator of risk if a vulnerable person lives alone, or has no carer. As the focus of care increasingly moves to the community, it is important to monitor the degree of need, the amount of formal care given, and the presence of a carer. This helps to establish how much of the overall burden is being absorbed by the 'informal' caring system.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

01	Person independent
02	No carer available
03	Has a co-resident carer
04	Has a non-resident carer
05	Lives in a mutually dependent situation
06	Not applicable person in residential care
07	Not stated/inadequately described

Guide for use: This includes people who receive payment such as a special benefit or pension. This excludes formal services such as delivered meals or home help, persons arranged by formal services such as volunteers, and funded group housing or similar situations. Availability infers carer willingness and ability to undertake the caring role and can apply when there are several carers. Where a potential carer is not prepared to undertake the role, or when their capacity to carry out necessary tasks is minimal, then the person must be coded as not having 'No carer available'.

Where there are several carers, a decision should be taken as to which of these is the main or primary carer and code accordingly. The following descriptions may assist in the selection of the most appropriate data.

Carer availability (*continued*)

- Guide for use (cont'd):**
1. PERSON INDEPENDENT indicates that the person has no need for assistance from informal carers.
 2. NO CARER AVAILABLE means that the person needs a carer but has no one able to provide informal care.
 3. HAS A CO-RESIDENT CARER (excludes Code 5) means that the person has a carer who is living in the same household.
 4. HAS A NON-RESIDENT CARER means that the person has a carer who is living in a different household.
 5. LIVES IN A MUTUALLY DEPENDENT SITUATION (excludes Code 3) refers to those households where the service recipient and another person are mutually dependent. The critical aspect of such households is that if either member becomes unavailable for any reason, the other is either at high risk or unable to remain at home.
 6. NOT APPLICABLE PERSON IN RESIDENTIAL CARE – services are provided by a formal agency in a supported accommodation or other care facility.
 99. NOT STATED/INSUFFICIENTLY DESCRIBED means that there is insufficient information to determine carer availability.

Verification rules:

Collection methods: Carer availability is to be collected at admission and again at discharge. The discharge information refers to the status immediately prior to the discharge, and not the need of the service recipient after the event.

Related data: supersedes previous data element Carer availability, version 1

Administrative attributes

Source document:

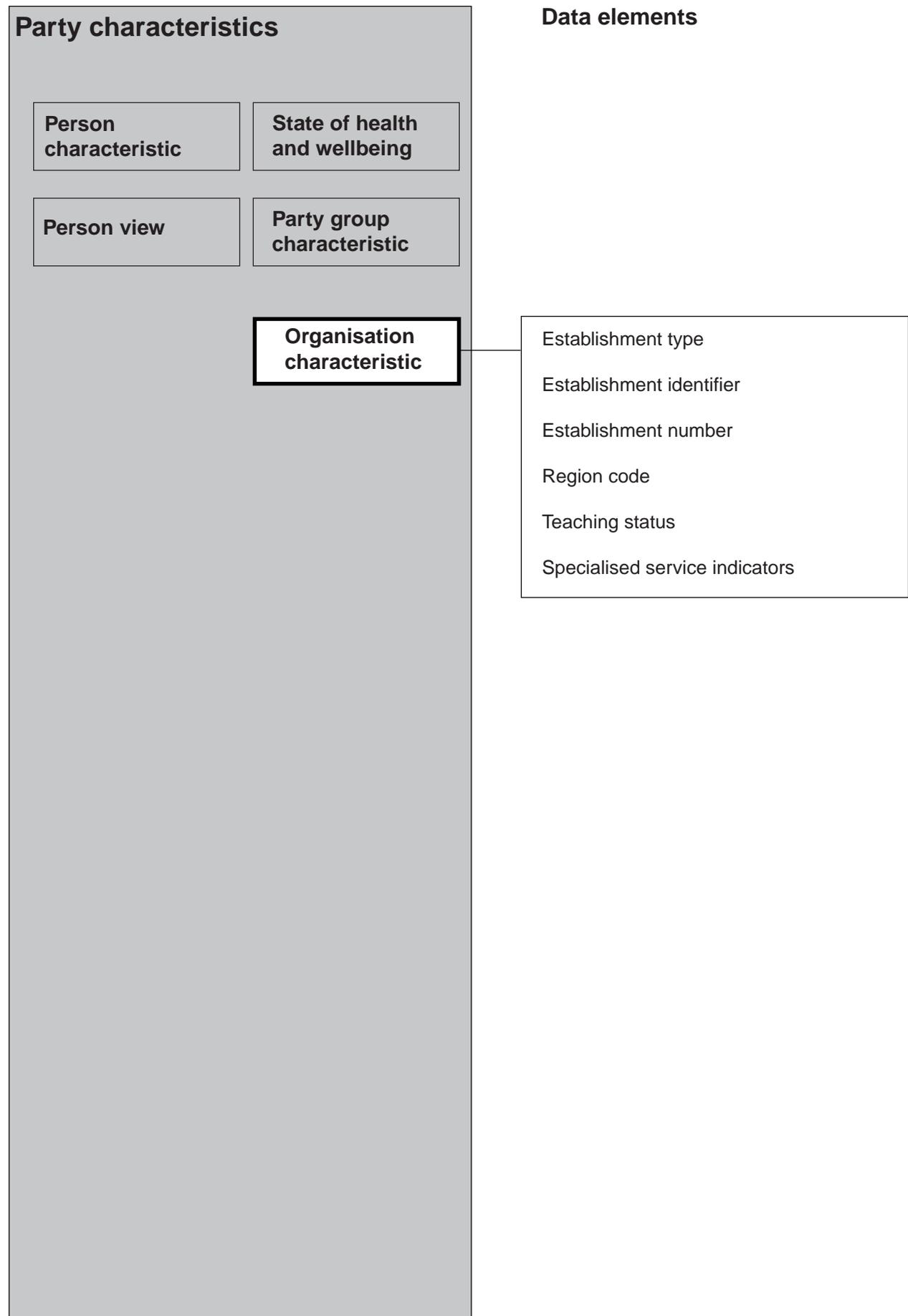
Source organisation: Australian Council of Community Nursing Services

National minimum data sets:

Comments: The original item 'Carer Availability' in Version 1.0 of the CNMDSA has been split into two items 'Carer Availability' and 'Living Arrangement'. Users of the CNMDSA found the original item difficult to apply as it was seeking to do two things: describe the carer availability and the person's living arrangements within one item. The new item 'Living Arrangement' is introduced to clarify meaning and describe each item more clearly.

The reason for collection at both admission and discharge is that over a care episode, a change in carer status may occur either because the caring load increases, and/or, the carer's ability or willingness to undertake the role ceases or is diminished. This may necessitate discharge of the person from care, and has implications for health service utilisation. The coding options are therefore identical to enable comparison of the admission and discharge states. The discharge information refers to the person's state when care was being delivered, not after their discharge from care.

National Health Information Model entities



Establishment type

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000327 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Type of establishment (defined in terms of legislative approval, service provided and patients treated) for each separately administered establishment.

Residential establishments are considered to be separately administered if managed as an independent unit in terms of financial, budgetary and activity statistics. The situation where establishment-level data, say for components of an area health service, were not available separately at a central authority was not grounds for treating such a group of establishments as a single establishment unless such data were not available at any level in the health care system.

Non-residential health services are classified in terms of separately administered organisations rather than in terms of the number of sites at which care is delivered. Thus, domiciliary nursing services would be counted in terms of the number of administered entities employing nursing staff rather than in terms of the number of clinic locations used by the staff.

Establishments can cater for a number of activities and in some cases separate staff and financial details are not available for each activity. In the cases it is necessary to classify the establishment according to its predominant residential activity (measured by costs) and to allocate all the staff and finances to that activity. Where non-residential services only are provided at one establishment, that establishment is classified according to the predominant non-residential activity (in terms of costs).

Context: Health services: type of establishment is required in order to aggregate establishment-level data into meaningful summary categories (for example, public hospitals, nursing homes) for reporting and analysis.

Relational and representational attributes

Datatype: Alphanumeric *Representational form:* CODE

Field size: *Min.* 2 *Max.* 6 *Representational layout:* AN.N.N

Data domain:

- N7.1 Public day centre/hospital
- N7.2 Public freestanding day surgery centre
- N7.3 Private day centre/hospital
- N7.4 Private freestanding day surgery centre
- N8.1.1 Public community health centre
- N8.1.2 Private (non-profit) community health centre
- N8.2.1 Public domiciliary nursing service
- N8.2.2 Private (non-profit) domiciliary nursing service
- N8.2.3 Private (profit) domiciliary nursing service

Establishment type (*continued*)

Data domain (cont'd):

R1.1	Public acute care hospital
R1.2	Private acute care hospital
R1.3.1	Veterans Affairs hospital
R1.3.2	Defence force hospital
R1.3.3	Other Commonwealth hospital
R2.1	Public psychiatric hospital
R2.2	Private psychiatric hospital
R3.1	Private charitable nursing home for the aged
R3.2	Private profit nursing home for the aged
R3.3	Government nursing home for the aged
R3.4	Private charitable nursing home for young disabled
R3.5	Private profit nursing home for young disabled
R3.6	Government nursing home for young disabled
R4.1	Public alcohol and drug treatment centre
R4.2	Private alcohol and drug treatment centre
R5.1	Charitable hostels for the aged
R5.2	State government hostel for the aged
R5.3	Local government hostel for the aged
R5.4	Other charitable hostel
R5.5	Other state government hostel
R5.6	Other local government hostel
R6.1	Public hospice
R6.2	Private hospice

Guide for use: Establishments are classified into 10 major types subdivided into major groups:
- residential establishments (R)
- non-residential establishments (N)

R1 Acute care hospitals

Establishments which provide at least minimal medical, surgical or obstetric services for in-patient treatment and/or care, and which provide round-the-clock comprehensive qualified nursing service as well as other necessary professional services. They must be licensed by the State health department, or controlled by government departments. Most of the patients have acute conditions or temporary ailments and the average stay per admission is relatively short.

Hospitals specialising in dental, ophthalmic aids and other specialised medical or surgical care are included in this category. Hospices (establishments providing palliative care to terminally ill patients) that are freestanding and do not provide any other form of acute care are classified to R6.

R2 Psychiatric hospitals

Establishments devoted primarily to the treatment and care of in-patients with psychiatric, mental, or behavioural disorders. Private hospitals formerly approved by the Commonwealth Department of Health under the Health Insurance Act 1973 (Cwlth) (now licensed/approved by each State health authority), catering primarily for patients with psychiatric or behavioural disorders are included in this category.

Establishment type (*continued*)

Guide for use (cont'd): Centres for the non-acute treatment of drug dependence, developmental and intellectual disability are not included here (see below). This code also excludes institutions mainly providing living quarters or day care.

R3 Nursing homes

Establishments which provide long-term care involving regular basic nursing care to chronically ill, frail, disabled or convalescent persons or senile in-patients. They must be approved by the Commonwealth Department of Health and Aged Care and / or licensed by the State, or controlled by government departments.

Private profit nursing homes are operated by private profit making individuals or bodies.

Private charitable nursing homes are participating nursing homes operated by religious and charitable organisations.

Government nursing homes are nursing homes either operated by or on behalf of a State or Territory government.

R4 Alcohol and drug treatment centres

Freestanding centres for the treatment of drug dependence on an in-patient basis.

R5 Hostels and residential services

Establishments run by public authorities or registered non-profit organisation to provide board, lodging or accommodation for the aged, distressed or disabled who cannot live independently but do not need nursing care in a hospital or nursing home. Only hostels subsidised by the Commonwealth are included.

Separate dwellings are not included, even if subject to an individual rental rebate arrangement. Residents are generally responsible for their own provisions, but may be provided in some establishments with domestic assistance (meals, laundry, personal care). Night shelters providing only casual accommodation are excluded.

R6 Hospices

Establishments providing palliative care to terminally ill patients. Only freestanding hospices which do not provide any other form of acute care are included in this category.

N7 Same-day establishments

Includes both the traditional day centre/hospital and also freestanding day surgery centres.

Day centres/hospitals are establishments providing a course of acute treatment on a full-day or part-day non-residential attendance basis at specified intervals over a period of time. Sheltered workshops providing occupational or industrial training are excluded.

Freestanding day surgery centres are hospital facilities providing investigation and treatment for acute conditions on a day-only basis and are approved by the Commonwealth for the purposes of basic table health insurance benefits.

Establishment type (*continued*)

Guide for use (cont'd): N8 Non-residential health services

Services administered by public authorities or registered non-profit organisations which employ full-time equivalent medical or paramedical staff (nurses, nursing aides, physiotherapists, occupational therapists and psychologists, but not trade instructors or teachers). This definition distinguishes health services from welfare services (not within the scope of the National Minimum Data Project) and thereby excludes such services as sheltered workshops, special schools for the intellectually disabled, meals on wheels and baby clinics offering advisory services but no actual treatment. Non-residential health services should be enumerated in terms of services or organisations rather than in terms of the number of sites at which care is delivered.

Non-residential health services provided by a residential establishment (for example, domiciliary nursing service which is part of a public hospital) should not be separately enumerated.

N8.1 Community health centres

Public or registered non-profit establishments in which a range of non-residential health services is provided in an integrated and coordinated manner, or which provides for the coordination of health services elsewhere in the community.

N8.2 Domiciliary nursing service

Public or registered non-profit or profit making establishments providing nursing or other professional paramedical care or treatment to patients in their own homes or in (non-health) residential institutions. Establishments providing domestic or housekeeping assistance are excluded by the general definition above.

Note that national minimum data sets currently include only community health centres and domiciliary nursing services.

Verification rules:

Collection methods:

Related data:

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Comments:

In the current data element, the term establishment is used in a very broad sense to mean bases, whether institutions, organisations or the community from which health services are provided. Thus, the term covers conventional health establishments and also organisations which may provide services in the community.

This data element is currently under review by the Organisaitonal Units Working Group of the National Health Data Committee. Recommendations will provide a comprehensive coverage of the health service delivery sector.

Establishment identifier

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000050 *Version number:* 2

Data element type: COMPOSITE ELEMENT

Definition: Identifier for the establishment in which episode or event occurred. Each separately administered health care establishment to have a unique identifier at the national level.

Context: Institutional health care

Relational and representational attributes

Datatype: Alphanumeric *Representational form:* CODE

Field size: *Min.* 6 *Max.* 6 *Representational layout:* NNANNN

Data domain: Concatenation of:
 N – State identifier
 N – Establishment sector
 A – Region code
 NNN – Establishment number

Guide for use: If data is supplied on computer media, this item is only required once in the header information. If information is supplied manually, this item should be provided on each form submitted.

Verification rules:

Collection methods:

Related data: is composed of State identifier, version 2
 is composed of Establishment sector, version 2
 is composed of Region code, version 2
 is composed of Establishment number, version 2
 supersedes previous data element Establishment identifier, version 1

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional mental health care	from 1/07/97 to
Perinatal	from 1/07/97 to
Community mental health care	from 1/07/98 to
Palliative care	from 1/07/2000 to

Establishment identifier (*continued*)

Comments:

A residential establishment is considered to be separately administered if managed as an independent institution for which there are financial, budgetary and activity statistics. For example, if establishment-level data for components of an area health service are not available separately at a central authority, this is not grounds for treating such components as a single establishment unless such data are not available at any level in the health care system.

This item is now being used to identify hospital contracted care. The use of this item will lead to reduced duplication in reporting patient activity and will enable linkage of services to one episode of care.

Establishment number

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000377 *Version number:* 2

Data element type: DATA ELEMENT

Definition: An identifier for establishment, unique within the State or Territory.

Context: Institutional health care

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data: is a composite part of Establishment identifier, version 2

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

Institutional health care from 1/07/89 to

Institutional mental health care from 1/07/97 to

Perinatal from 1/07/97 to

Emergency Department waiting times from 1/07/99 to

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

Region code

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000378 *Version number:* 2

Data element type: DATA ELEMENT

Definition: An identifier for location of health services in an area.

Context: Health services

Relational and representational attributes

Datatype: Alphanumeric *Representational form:* CODE

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

Data domain:

Guide for use: Domain values are specified by individual States/Territories

Verification rules:

Collection methods:

Related data: is a composite part of Establishment identifier, version 2

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

Institutional health care from 1/07/89 to

Institutional mental health care from 1/07/97 to

Perinatal from 1/07/97 to

Comments:

Teaching status

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000322 *Version number:* 1

Data element type: DATA ELEMENT

Definition: An indicator (yes / no) to identify the non-direct patient care activity of teaching for a particular establishment. This is where teaching (associated with a university) is a major program activity of the establishment. It is primarily intended to relate to teaching hospitals affiliated with universities providing undergraduate medical education as advised by the relevant State health authority.

Context: Health services: the non-direct care activity of teaching can involve the consumption of considerable resources. In comparisons of cost in relation to establishment output, it is important to be aware of particular establishments which are devoting substantial resources to activities not relating to output as measured in terms of either in-patient bed days or outpatient occasions of service. Teaching can be one of the variables in any regression analysis undertaken.

In this context, teaching relates to teaching hospitals affiliated with universities providing undergraduate medical education as advised by the relevant State health authority.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

1	Yes
2	No
9	Unknown

Guide for use:

Verification rules:

Collection methods:

Related data: relates to the data element Establishment type, version 1

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Comments: The initial intention based on the Taskforce on National Hospital Statistics approach had been to have non-direct care activity indicators for all of the following non-direct patient care activities:

Teaching status (*continued*)

- Comments (cont'd):*
- teaching,
 - research,
 - group or community contacts,
 - public health activities,
 - mobile centre and/or part-time service.

However, the Resources Working Party decided to delete 2, 3, 4 and 5 and place the emphasis on teaching where teaching (associated with a university) was a major program activity of the hospital. The working party took the view that it was extremely difficult to identify research activities in health institutions because many staff consider that they do research as part of their usual duties. The research indicator was thus deleted and the teaching indicator was agreed to relate to teaching hospitals affiliated with universities providing undergraduate medical education, as advised by the relevant State health authority. If a teaching hospital is identified by a yes/no indicator then it is not necessary to worry about research (based on the assumption that if you have teaching, you have research).

Specialised service indicators

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000321 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Specialised services provided in establishments.

Context: Health services: essential to provide a broad picture of the availability of these key specialised services by State and region and to assist with planning if services are over supplied in one region relative to another.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 5 *Representational layout:* AN.NN

Data domain: 1 Yes
2 No

Guide for use: Each of the following specialised services should be coded separately.

E4.1 Obstetric / maternity service

A specialised facility dedicated to the care of obstetric/maternity patients.

E4.2 Specialist paediatric service

A specialised facility dedicated to the care of children aged 14 or less.

E4.3 Psychiatric unit / ward

A specialised unit / ward dedicated to the treatment and care of admitted patients with psychiatric, mental, or behavioural disorders.

E4.4. Intensive care unit (level III)

A specialised facility dedicated to the care of paediatric and adult patients requiring intensive care and sophisticated technological support services.

E4.5 Hospice care unit

A facility dedicated to the provision of palliative care to terminally ill patients.

E4.6 Nursing home care unit

A facility dedicated to the provision of nursing home care.

E4.7 Geriatric assessment unit

Facilities dedicated to the Commonwealth-approved assessment of the level of dependency of (usually) aged individuals either for purposes of initial admission to a long-stay institution or for purposes of reassessment of dependency levels of existing long-stay institution residents.

E4.8 Domiciliary care service

A facility/service dedicated to the provision of nursing or other professional paramedical care or treatment and non-qualified domestic assistance to patients in their own homes or in residential institutions not part of the establishment.

Specialised service indicators (*continued*)

Guide for use (cont'd): E4.9 Alcohol and drug unit

A facility/service dedicated to the treatment of alcohol and drug dependence.

E4.10 Acute spinal cord injury unit (SS)

A specialised facility dedicated to the initial treatment and subsequent ongoing management and rehabilitation of patients with acute spinal cord injury, largely conforming to Australian Health Minister's Advisory Council guidelines for service provision.

E4.11 Coronary care unit

A specialised facility dedicated to acute care services for patients with cardiac diseases.

E4.12 Cardiac surgery unit (SS)

A specialised facility dedicated to operative and peri-operative care of patients with cardiac disease.

E4.13 Acute renal dialysis unit (SS)

A specialised facility dedicated to dialysis of renal failure patients requiring acute care.

E4.14 Maintenance renal dialysis centre (SS)

A specialised facility dedicated to maintenance dialysis of renal failure patients. It may be a separate facility (possibly located on hospital grounds) or known as a satellite centre or a hospital-based facility but is not a facility solely providing training services.

E4.15 Burns unit (level III) (SS)

A specialised facility dedicated to the initial treatment and subsequent rehabilitation of the severely injured burns patient (usually >10 per cent of patients body surface affected).

E4.16 Major plastic/reconstructive surgery unit (SS)

A specialised facility dedicated to general purpose plastic and specialised reconstructive surgery, including maxillofacial, microsurgery and hand surgery.

E4.17 Oncology (cancer treatment) unit (SS)

A specialised facility dedicated to multidisciplinary investigation, management, rehabilitation and support services for cancer patients. Treatment services include surgery, chemotherapy and radiation.

E4.18 Neonatal intensive care unit (level III) (SS)

A specialised facility dedicated to the care of neonates requiring care and sophisticated technological support. Patients usually require intensive cardiorespiratory monitoring, sustained assistance ventilation, long-term oxygen administration and parenteral nutrition.

E4.19 In-vitro fertilisation unit

A specialised facility dedicated to the investigation of infertility provision of in-vitro fertilisation services.

Specialised service indicators (*continued*)

Guide for use (cont'd): E4.20 Comprehensive epilepsy centre (SS)

A specialised facility dedicated to seizure characterisation, evaluation of therapeutic regimes, pre-surgical evaluation and epilepsy surgery for patients with refractory epilepsy.

E4.21 Transplantation unit

A specialised facility dedicated to organ retrieval, transplantation and ongoing care of the transplant recipient.

- bone marrow
- renal
- heart, including heart-lung
- liver
- pancreas

E4.22 Clinical genetics unit (SS)

A specialised facility dedicated to diagnostic and counselling services for clients who are affected by, at risk of or anxious about genetic disorders.

E4.23 Sleep centre

A specialised facility linked to a sleep laboratory dedicated to the investigation and management of sleep disorders.

E4.24 Neuro surgical unit

A specialised facility dedicated to the surgical treatment of neurological conditions.

E4.25 Infectious diseases unit

A specialised facility dedicated to the treatment of infectious diseases.

E4.26 AIDS unit

A specialised facility dedicated to the treatment of AIDS patients.

E4.27 Diabetes unit

A specialised facility dedicated to the treatment of diabetics.

E4.28 Rehabilitation unit

Dedicated units within recognised hospitals which provide post-acute rehabilitation and are designed as such by the State health authorities (see data element 'Type of episode of care').

Verification rules:

Collection methods:

Related data: relates to the data element Establishment type, version 1

Administrative attributes

Source document:

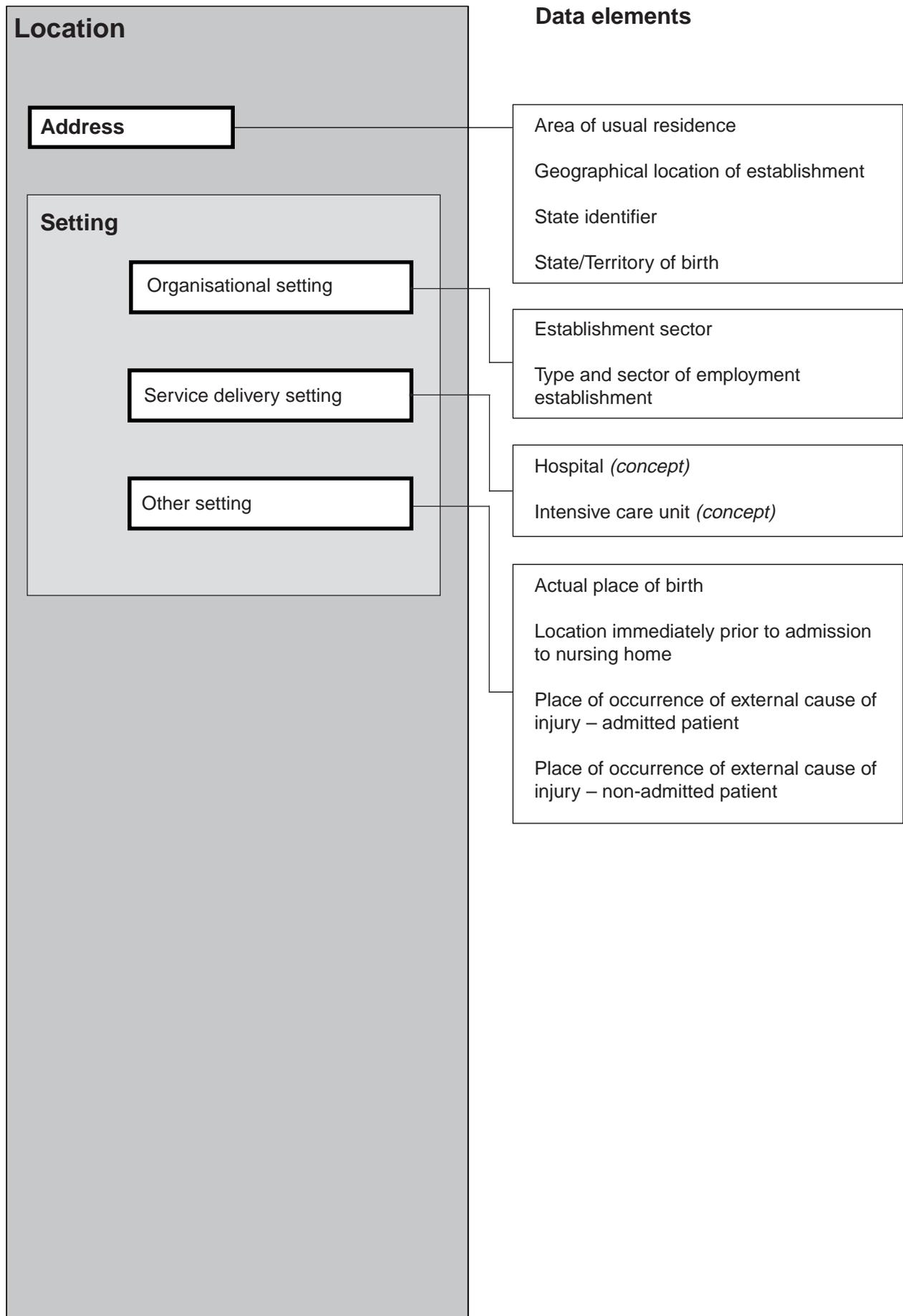
Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Comments:

National Health Information Model entities



Area of usual residence

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000016 *Version number:* 3

Data element type: DATA ELEMENT

Definition: Geographical location of usual residence of the person.

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

Analyses facilitated by the inclusion of Statistical Local Area information include

- comparison of the use of services by persons residing in different geographical areas,
- characterisation of catchment areas and populations for establishments for planning purposes, and
- documentation of the provision of services to residents of States or Territories other than the State or Territory of the provider.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain: The geographical location is reported using a five digit numerical code. The first digit is the single-digit code to indicate State or Territory. The remaining four digits are the numerical code for the Statistical Local Area (SLA) within the State or Territory.

The single digit codes for the States and Territories and the four digit codes for the SLAs are as defined in the Australian Standard Geographical Classification (Australian Bureau of Statistics, catalogue number 1216.0).

Guide for use: The Australian Standard Geographical Classification (ASGC) is updated on an annual basis with a date of effect of 1 July each year. Therefore, the edition effective for the data collection reference year should be used.

The codes for Statistical Local Areas are unique within each State and Territory, but not within the whole country. Thus, to define a unique location, the code of the State or Territory is required in addition to the code for the Statistical Local Area.

The Australian Bureau of Statistics' National Localities Index (NLI) (ABS Catalogue number 1252.0) can be used to assign each locality or address in

Area of usual residence (*continued*)

Guide for use (cont'd): Australia to a Statistical Local Area. The NLI is a comprehensive list of localities in Australia with their full code (including State or Territory and Statistical Local Area) from the main structure of the ASGC.

For the majority of localities, the locality name (suburb or town, for example) is sufficient to assign a Statistical Local Area. However, some localities have the same name. For most of these, limited additional information such as the postcode or State can be used with the locality name to assign the Statistical Local Area. In addition, other localities cross one or more Statistical Local Area boundaries and are referred to as split localities. For these, the more detailed information of the number and street of the person's residence is used with the Streets Sub-index of the NLI to assign the Statistical Local Area.

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

The NLI does not assign a Statistical Local Area code if the information about the address is insufficient to identify a locality, or is not an Australian locality. In these cases, the appropriate codes for undefined Statistical Local Area within Australia (State or Territory unstated), undefined Statistical Local Area within a stated State or Territory, no fixed place of abode (within Australia or within a stated State or Territory) or overseas should be used.

Verification rules:

Collection methods:

Related data: supersedes previous data element Area of usual residence, version 2

Administrative attributes

Source document: Australian Standard Geographical Classification (ASGC)

Source organisation: National Health Data Committee

National minimum data sets:

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

Comments:

Geographical location of establishment

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000260 *Version number:* 2

Data element type: DATA ELEMENT

Definition: Geographical location of the establishment. For establishments with more than one geographical location, the location is defined as that of the main administrative centre.

Context: Health services: To enable the analysis of service provision in relation to demographic and other characteristics of the population of a geographic area.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain: The geographical location is reported using a five digit numerical code to indicate the Statistical Local Area (SLA) within the reporting State or Territory, as defined in the Australian Standard Geographical Classification (Australian Bureau of Statistics, catalogue number 1216.0).

Guide for use: The Australian Standard Geographical Classification (ASGC) is updated on an annual basis with a date of effect of 1 July each year. Therefore, the edition effective for the data collection reference year should be used.

The Australian Bureau of Statistics' National Localities Index (NLI) can be used to assign each locality or address in Australia to an SLA. The NLI is a comprehensive list of localities in Australia with their full code (including SLA) from the main structure of the ASGC.

For the majority of localities, the locality name (suburb or town, for example) is sufficient to assign an SLA. However, some localities have the same name. For most of these, limited additional information such as the postcode or State can be used with the locality name to assign the SLA.

In addition, other localities cross one or more SLA boundaries and are referred to as split localities. For these, the more detailed information of the number and street of the establishment is used with the Streets Sub-index of the NLI to assign the SLA.

Verification rules:

Collection methods:

Related data: supersedes previous data element Geographic location, version 1
relates to the data element Establishment type, version 1

Administrative attributes

Source document: Australian Standard Geographical Classification (Australian Bureau of Statistics Catalogue No. 1216.0)

Source organisation: National Health Data Committee

Geographical location of establishment (*continued*)

National minimum data sets:

Institutional health care from 1/07/89 to

Community mental health care from 1/07/98 to

Comments: The geographical location does not provide direct information on the geographical catchment area or catchment population of the establishment.

State identifier

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000380 *Version number:* 2

Data element type: DATA ELEMENT

Definition: An identifier for State or Territory.

Context: Health services

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

1	New South Wales
2	Victoria
3	Queensland
4	South Australia
5	Western Australia
6	Tasmania
7	Northern Territory
8	Australian Capital Territory
9	Other territories (Cocos (Keeling) Islands, Christmas Island and Jervis Bay Territory)

Guide for use:

Verification rules:

Collection methods:

Related data: is a composite part of Establishment identifier, version 2

Administrative attributes

Source document: Domain values are derived from the Australian Standard Geographic Classification (Australian Bureau of Statistics, Catalogue Number 1216.0)

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Institutional mental health care from 1/07/97 to

Perinatal from 1/07/97 to

Comments:

State / Territory of birth

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000155 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The State/Territory in which the birth occurred.

Context: Perinatal statistics: to enable analyses by State/Territory of delivery.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

0	Not applicable (includes resident overseas, no fixed address)
1	New South Wales
2	Victoria
3	Queensland
4	South Australia
5	Western Australia
6	Tasmania
7	Northern Territory
8	Australian Capital Territory
9	External Australian territories (Cocos (Keeling) Islands, Christmas Island and Jervis Bay Territory)

Guide for use:

Verification rules:

Collection methods:

Related data:

Administrative attributes

Source document:

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Perinatal from 1/07/97 to

Comments:

Establishment sector

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000379 *Version number:* 2

Data element type: DATA ELEMENT

Definition: A section of the health care industry.

Context: Institutional health care

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

1	Public
2	Private
3	Repatriation

Guide for use:

Verification rules:

Collection methods:

Related data: relates to the data element Hospital, version 1
is a composite part of Establishment identifier, version 2

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

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

Comments:

Type and sector of employment establishment

Admin. status: CURRENT 1/07/95

Identifying and definitional attributes

Knowledgebase ID: 000166 *Version number:* 1

Data element type: DATA ELEMENT

Definition: For each health profession, type of employment establishment is a self reporting, condensed industry of employment classification that can be cross-referenced to the Australian and New Zealand Standard Industrial Classification.

Sector of employment establishment is government (public) or non-government (private), according to whether or not the employer is a Commonwealth, State or local government agency.

Context: Health labour force: to analyse distribution of service providers by setting (defined by industry of employer and sector), cross-classified with main type of work and/or specialty area.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

01	Private medical practitioner rooms/surgery (including 24-hour medical clinics)
02	Other public non-residential health care facility (e.g. Aboriginal health service, ambulatory centre, outpatient clinic, day surgery centre, medical centre, community health centre)
03	Other private non-residential health care (e.g. Aboriginal health service, ambulatory centre, outpatient clinic, day surgery centre, medical centre, community health centre)
04	Hospital – acute care* (including psychiatric or specialist hospital) hospital (public)
05	Hospital – acute care (including psychiatric or specialist hospital) hospital (private)
06	Residential health care (e.g. nursing home, hospice, physical disabilities residential centre) facility (public)
07	Residential health care (e.g. nursing home, hospice, physical disabilities residential centre) facility (private)
08	Tertiary education institution (public)
09	Tertiary education institution (private)
10	Defence forces
11	Government department or agency (e.g. laboratory, research organisation etc.)
12	Private industry/private enterprise (e.g. insurance, pathology, bank)
13	Other (specified) Public
14	Other (specified) Private
99	Unknown/ inadequately described/not stated

Type and sector of employment establishment (*continued*)

Guide for use: Establishments are coded into self reporting groupings in the public and private sectors. This can be seen below in the code list for medical practitioners.

Minor variations in ordering of sequence and disaggregation of the principal categories will be profession-specific as appropriate; where a more detailed set of codes is used, the essential criterion is that there should not be an overlap of the detailed codes across the Australian and New Zealand Standard Industrial Classification category definitions.

Note:

Public psychiatric hospitals are non-acute care facilities, whereas private psychiatric hospitals are acute care facilities. To minimise the possibility of respondent confusion and mis-reporting, public psychiatric hospitals are included in the grouping for acute care public hospitals.

Day surgery centres, outpatient clinics and medical centres approved as hospitals under the Health Insurance Act 1973 (Cwlth) have emerged as a new category for investigation. These will be included in a review of the National Health Labour Force Collection questions and coding frames.

Verification rules:

Collection methods:

Related data:

Administrative attributes

Source document:

Source organisation: National Health Labour Force Data Working Group

National minimum data sets:

Health labourforce from 1/07/89 to

Comments:

Hospital

Admin. status: CURRENT 1/07/94

Identifying and definitional attributes

Knowledgebase ID: 000064 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

Definition: A health care facility established under Commonwealth, State or Territory legislation as a hospital or a free-standing day procedure unit and authorised to provide treatment and/or care to patients.

Context: Institutional health care

Relational and representational attributes

Datatype: *Representational form:*

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

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data: relates to the data element Establishment sector, version 2

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Comments: A hospital thus defined may be located at one physical site or may be a multicampus hospital. A multicampus hospital treats movements of patients between sites as ward transfers.

For the purposes of these definitions, the term hospital includes satellite units managed and staffed by the hospital.

This definition includes, but is not limited to, hospitals as recognised under Australian Health Care Agreements.

Nursing homes as approved under the National Health Act 1953 (Cwlth) or equivalent State legislation and hostels approved under the Aged or Disabled Persons Care Act 1954 (Cwlth) are excluded from this definition.

This definition includes entities with multipurpose facilities (e.g. those which contain both recognised and non-recognised components).

Intensive care unit

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000078 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

Definition: An intensive care unit (ICU) is a designated ward of a hospital which is specially staffed and equipped to provide observation, care and treatment to patients with actual or potential life-threatening illnesses, injuries or complications, from which recovery is possible. The ICU provides special expertise and facilities for the support of vital functions and utilises the skills of medical, nursing and other staff trained and experienced in the management of these problems.

Context: Institutional health care

Relational and representational attributes

Datatype: *Representational form:*

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

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data:

Administrative attributes

Source document:

Source organisation: National Intensive Care Working Group

National minimum data sets:

Comments: There are five different types and levels of ICU defined according to three main criteria: the nature of the facility, the care process and the clinical standards and staffing requirements. All levels and types of ICU must be separate and self-contained facilities in hospitals and, for clinical standards and staffing requirements, substantially conform to relevant guidelines of the Australian Council on Healthcare Standards. The five types of ICU are briefly described below:

Adult intensive care unit .level 3: must be capable of providing complex, multisystem life support for an indefinite period; be a tertiary referral centre for patients in need of intensive care services and have extensive backup laboratory and clinical service facilities to support the tertiary referral role. It must be capable of providing mechanical ventilation, extracorporeal renal support services and invasive cardiovascular monitoring for an indefinite period; or care of a similar nature.

Intensive care unit (*continued*)

Comments (cont'd): Adult intensive care unit, level 2: must be capable of providing complex, multisystem life support and be capable of providing mechanical ventilation, extracorporeal renal support services and invasive cardiovascular monitoring for a period of at least several days, or for longer periods in remote areas or care of a similar nature (see ACHS guidelines)

Adult intensive care unit, level 1: must be capable of providing basic multisystem life support usually for less than a 24 hour period. It must be capable of providing mechanical ventilation and simple invasive cardiovascular monitoring for a period of at least several hours; or care of a similar nature.

Paediatric intensive care unit: must be capable of providing complex, multisystem life support for an indefinite period; be a tertiary referral centre for children needing intensive care and have extensive backup laboratory and clinical service facilities to support this tertiary role. It must be capable of providing mechanical ventilation, extracorporeal renal support services and invasive cardiovascular monitoring for an indefinite period to infants and children less than 16 years of age; or care of a similar nature.

Neonatal intensive care unit, level 3: must be capable of providing complex, multisystem life support for an indefinite period. It must be capable of providing mechanical ventilation and invasive cardiovascular monitoring; or care of a similar nature.

Definitions for high-dependency unit, coronary care unit are under development.

Actual place of birth

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000003 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The actual place where the birth occurred.

Context: Perinatal statistics: used to analyse the risk factors and outcomes by place of birth. While most deliveries occur within hospitals an increasing number of births now occur in other settings. It is important to monitor the births occurring outside hospitals and to ascertain whether or not the actual place of delivery was planned.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

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

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

Verification rules:

Collection methods:

Related data: is a qualifier of Intended place of birth, version 1

Administrative attributes

Source document:

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Perinatal from 1/07/97 to

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

Location immediately prior to admission to nursing home

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000084 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Source from which the patient was transferred/referred to the hospital.

Context: Nursing home statistics: to assist in analyses of intersectoral patient flow and health care planning.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

1	Home (usual residence)
2	Home of relative (but not usual residence)
3	Hostel
4	Other residence
5	Acute hospital
6	Other hospital
7	Nursing home (check on transfers)
8	Other location
9	Unknown

Guide for use:

Verification rules:

Collection methods:

Related data:

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

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

Place of occurrence of external cause of injury – admitted patient

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000384 *Version number:* 4

Data element type: DATA ELEMENT

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

Context: Admitted patients: 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

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

Data domain: ICD-10-AM

Guide for use: All admitted patients should be coded to the ICD-10-AM classification. In ICD-10-AM place of occurrence is the fourth character of the external cause code.

A place of occurrence code must accompany those external cause codes specified in the range W00-Y34 (with the exception of Y06 and Y07. Refer to the Australian Coding Standards for ICD-10-AM, National Centre for Classification in Health, Sydney for further details.

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

Verification rules:

Collection methods:

Related data: supersedes previous data element Place of occurrence of external cause of injury – admitted patient – ICD-9-CM, version 3

is used in conjunction with External cause – admitted patient, 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 and National Centre for Classification in Health.

National minimum data sets:

Institutional health care from 1/07/89 to

Injury surveillance from 1/07/89 to

Comments:

Place of occurrence of external cause of injury – non-admitted patient

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000128 *Version number:* 3

Data element type: DATA ELEMENT

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

Context: Injury surveillance (non-admitted patients): 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

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

Data domain:

01	Home (includes farm house)
02	Residential institution (excludes hospital [04])
03	School, other institutional or public administrative area
04	Hospital or other health service
05	Place of recreation (mainly for informal recreational activities)
06	Sports and athletics area (mainly for formal sports etc.)
07	Street or highway
08	Trade or service area
09	Industrial or construction area
10	Mine or quarry
11	Farm (excludes farm house [01])
12	Other specified places
13	Unspecified place

Guide for use: To be used only for injury surveillance purposes for non-admitted patients when it is not possible to use ICD-10-AM codes. New South Wales, Australian Capital Territory, Victoria and the Northern Territory implemented ICD-10-AM from 1 July 1998. Other States will implement ICD-10-AM from 1 July 1999.

Select the code which best characterises the type of place where the person was situated when 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:

Collection methods:

Place of occurrence of external cause of injury – non-admitted patient (*continued*)

Related data: supersedes previous data element Place of occurrence of external cause, version 2
is used in conjunction with External cause – non-admitted patient, version 4

Administrative attributes

Source document:

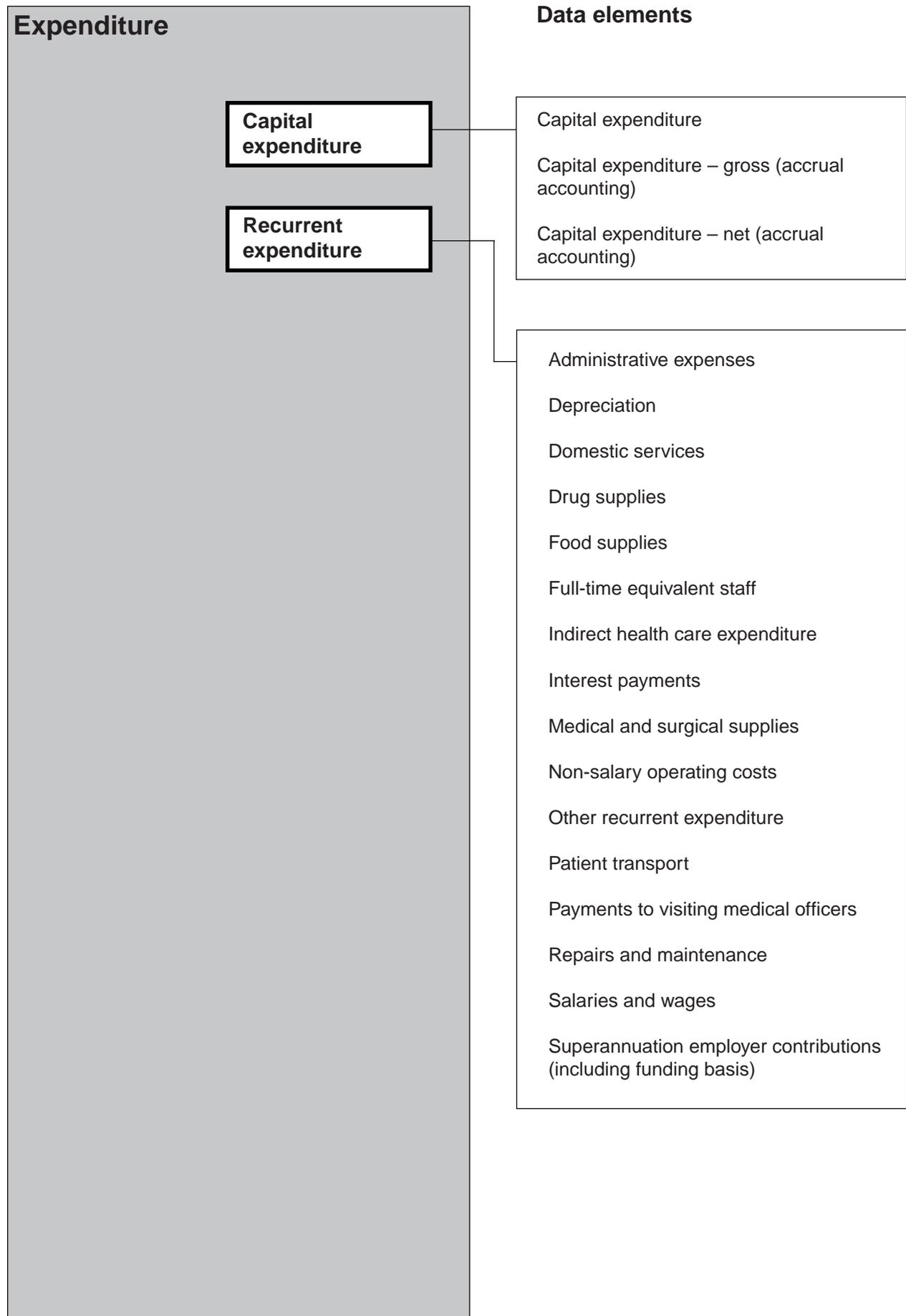
Source organisation: Australian Institute of Health and Welfare National Injury Surveillance Unit and National Data Standards for Injury Surveillance Advisory Group

National minimum data sets:

Injury surveillance from 1/07/89 to

Comments: Further information on the national injury surveillance program may be obtained from the National Injury Surveillance Unit, Flinders University, Adelaide.

National Health Information Model entities



Capital expenditure

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000248 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Gross capital expenditure is capital expenditure as reported by the particular establishment having regard to State health authority and other authoritative guidelines as to the differentiation between capital and recurrent expenditure. (A concise indication of the basis on which capital and recurrent expenditure have been differentiated is to form part of national minimum data sets).

Context: Health expenditure: capital expenditure is a significant, though variable, element of total health establishment expenditure. Just as recurrent expenditure is broken down into a number of major categories to enable a proper analysis of health expenditure at the national level, so capital expenditure is to be broken down into a number of major categories.

Capital expenditure in the context of hospitals and closely related establishments is a relatively undeveloped area. Nevertheless, there is a considerable interest in health establishment capital expenditure data at the national level from many different potential users.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 9 *Representational layout:* \$\$\$,\$\$\$,\$\$\$

Data domain:

1	Land and buildings
2	Computer equipment / installations
3	Major medical equipment
4	Plant and (other) equipment
5	Expenditure in relation to intangible assets
6	Other capital expenditure

Guide for use: Expenditure calculated separately for each type described below:

1. Land and buildings

This includes outlays on construction, major alterations and additions to buildings that relate to the establishment. Included are transfer and similar costs in respect of the purchase (sale) of second hand dwellings and installation of new permanent fixtures such as stoves, air conditioning, lighting, plumbing and other fixed equipment normally installed before dwellings are occupied. Costs relating to repair and maintenance replacement of buildings that amount to recurrent expenditure should not be included.

2. Computer equipment/installations

Expenditure of a capital nature on computer installations and equipment such as mainframe computers, mini-computers, extensive personal computer networks and related hardware should be included here.

Capital expenditure (*continued*)

Guide for use:

3. Major medical equipment

Expenditure on major items of medical equipment such as CT scanners, MRI equipment, X-ray equipment, ICU monitors and transplant equipment should be included here.

4. Plant and (other) equipment

Details of expenditure on plant and other equipment should be included here. Plant and/or equipment that is an integral part of any building or construction (and is thus included under expenditure on land and buildings), equipment included above under major medical equipment, motor vehicles and items of equipment that would normally be classified as recurrent expenditure should not be included.

5. Expenditure in relation to intangible assets

This category bears specific regard to the private sector. Included here is any expenditure during the financial year in respect of intangible assets such as formation expenses or goodwill.

6. Other capital expenditure

Any expenditure of a capital nature not included elsewhere should be included here. For example, if any State or establishment treats expenditure on new and second hand motor vehicles (including ambulances) as capital expenditure, this should be included as should any expenditure on furniture and fittings if treated by a State or establishment as expenditure of a capital nature.

Verification rules:

Collection methods:

Related data: relates to the data element Capital expenditure – net (accrual accounting), version 2
relates to the data element Capital expenditure – gross (accrual accounting), version 2

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

Institutional health care from 1/07/89 to

Comments:

Capital expenditure – gross (accrual accounting)

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000325 *Version number:* 2

Data element type: DATA ELEMENT

Definition: Expenditure in a period on the acquisition or enhancement of an asset (excluding financial assets).

Context: Health expenditure: gross capital expenditure is a significant, though variable, element of total health establishment expenditure. Just as recurrent expenditure is broken down into a number of major categories to enable a proper analysis of health expenditure at the national level, so capital expenditure is to be broken down into a number of major categories.

Capital expenditure in the context of hospitals and closely related establishments is a relatively undeveloped area. Nevertheless, there is a considerable interest in health establishment capital expenditure data at the national level from many different potential users.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 9 *Representational layout:* \$\$\$\$\$\$

Data domain:

1	Land
2	Buildings and building services (including plant)
3	Constructions (other than buildings)
4	Information technology
5	Major medical equipment
6	Transport
7	Other equipment
8	Intangible

Guide for use: This definition is for use where the accrual method of accounting has been adopted.

To be coded separately for each type of gross capital expenditure described below:

1. Land

A solid section of the earth's surface which is held by the entity under a certificate of title or reserve, leased in by the entity or allocated to the entity by another agency.

2. Buildings and building services (including plant)

An edifice that has a service potential constructed, acquired or held by a financial lease for the specific purposes of the entity. Includes hospitals, hostels, nursing homes and other buildings used for providing the service. Includes expenditure on installation, alteration and improvement of fixtures, facilities and equipment that are an integral part of the building and that contribute to the primary function of a building to either directly or indirectly support the delivery of products and services. Excludes repair and replacement of worn-out or damaged fixtures (to be treated as maintenance).

Capital expenditure – gross (accrual accounting) (*continued*)

Guide for use (cont'd): 3. Constructions (other than buildings)

Expenditure on construction, major alterations and additions to fixed assets other than buildings such as car parks, roads, bridges, storm water channels, dams, drainage and sanitation systems, sporting facilities, gas, water and electricity mains, communication systems, landscaping and grounds reticulation systems. Includes expenditure on land reclamation, land clearance and raising or levelling of building sites.

4-7. Equipment

An asset, not an integral part of any building or construction, used by an entity to support the delivery of products and services. Items may be fixed or moveable.

4. Information technology

Computer installations and equipment such as mainframe and mini-computers, personal computer networks and related hardware.

5. Major medical equipment

Major items of medical equipment such as medical imaging (CT scanners, MRI, radiology), ICU monitors and transplant equipment.

6. Transport

Expenditure on vehicles or equipment used for transport such as motor vehicles, aircraft, ships, railway, tramway rolling stock, and attachments (such as trailers). Includes major parts such as engines.

7. Other equipment

Includes machinery and equipment not elsewhere classified, such as furniture, art objects, professional instruments and containers.

8. Intangible

An asset which does not have physical substance, such as copyright, design, patent, trademark, franchise or licence.

Verification rules: Australian dollars. Rounded to the nearest whole dollar.

Collection methods:

Related data: supersedes previous data element Capital expenditure, version 1

relates to the data element Capital expenditure – net (accrual accounting), version 2

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

Institutional health care from 1/07/89 to

Comments: The capital expenditure data elements on an accrual accounting basis and on a cash accounting basis will remain in use until all health authorities have adopted accrual accounting.

Capital expenditure – net (accrual accounting)

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000396 *Version number:* 2

Data element type: DATA ELEMENT

Definition: Gross capital expenditure less trade-in values of replaced items and receipts from the sale of replaced or otherwise disposed items.

Context: Health expenditure: net capital expenditure is a significant, though variable, element of total health establishment expenditure. Just as recurrent expenditure is broken down into a number of major categories to enable a proper analysis of health expenditure at the national level, so capital expenditure is to be broken down into a number of major categories.

Capital expenditure in the context of hospitals and closely related establishments is a relatively undeveloped area. Nevertheless, there is a considerable interest in health establishment capital expenditure data at the national level from many different potential users.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 9 *Representational layout:* \$\$\$,\$\$\$,\$\$\$

Data domain:

1	Land
2	Buildings and building services (including plant)
3	Constructions (other than buildings)
4	Information technology
5	Major medical equipment
6	Transport
7	Other equipment
8	Intangible

Guide for use: To be calculated separately for each type of net capital expenditure described in 'capital expenditure – gross (accrual accounting)'.

Verification rules: Australian dollars. Rounded to nearest whole dollar.

Collection methods:

Related data: supersedes previous data element Capital expenditure, version 1
relates to the data element Capital expenditure – gross (accrual accounting), version 2

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

Institutional health care from 1/07/89 to

Comments:

Administrative expenses

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000244 *Version number:* 1

Data element type: DATA ELEMENT

Definition: All expenditure incurred by establishments (but not central administrations) of a management expenses/administrative support nature such as any rates and taxes, printing, telephone, stationery and insurance (including workers compensation).

Context: Health expenditure: considered to be a sufficiently significant element of non-salary recurrent expenditure as to be separately identified at the national level and also readily and easily collectable.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 9 *Representational layout:* \$\$\$,\$\$\$,\$\$\$

Data domain:

Guide for use:

Verification rules: Australian dollars. Rounded to nearest whole dollar.

Collection methods:

Related data: relates to the data element Establishment type, version 1

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Community mental health care from 1/07/98 to

Comments:

Depreciation

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000246 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Depreciation represents the expensing of a long-term asset over its useful life and is related to the basic accounting principle of matching revenue and expenses for the financial period. Depreciation charges for the current financial year only should be shown as expenditure. Where intangible assets are amortised (such as with some private hospitals) this should also be included in recurrent expenditure.

Context: Health expenditure: this item has been retained for national minimum data sets because of its significance for the private sector. Current period depreciation charges form a significant component of expenditure for any health establishment whose financial statements are based on accrual accounting.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 9 *Representational layout:* \$\$\$,\$\$\$,\$\$\$

Data domain:

Guide for use:

Verification rules: Australian dollars. Rounded to nearest whole dollar.

Collection methods:

Related data: relates to the data element Establishment type, version 1

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Community mental health care from 1/07/98 to

Comments: With the long-term trend towards accrual accounting in the public sector, this item will ultimately become significant for public sector establishments. Public sector establishments in some States have adopted modified accrual accounting identifying depreciation only, before reaching full accrual accounting. Depreciation is now reported (March 1999) for most public sector establishments and should be reported as a separate recurrent expenditure.

Depreciation should be identified separately from other recurrent expenditure categories.

Domestic services

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000241 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The costs of all domestic services including electricity, other fuel and power, domestic services for staff, accommodation and kitchen expenses but not including salaries and wages, food costs or equipment replacement and repair costs. Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers.

Context: Health expenditure: this is a significant element of non-salary recurrent expenditure for most establishments within the data set and is thus required for any health expenditure analysis at the national level.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 9 *Representational layout:* \$\$\$,\$\$\$,\$\$\$

Data domain:

Guide for use:

Verification rules: Australian dollars. Rounded to nearest whole dollar.

Collection methods:

Related data: relates to the data element Establishment type, version 1

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Community mental health care from 1/07/98 to

Comments: The possibility of separating fuel, light and power from domestic services which would bring the overall non-salary recurrent expenditure categories closer to the old Hospitals and Allied Services Advisory Council categories was briefly considered by the Resources Working Party but members did not hold strong views in this area.

Drug supplies

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000238 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The cost of all drugs including the cost of containers. Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers.

Context: Health expenditure: this is a significant element of non-salary recurrent expenditure and also national level data on drug expenditure in hospitals is of considerable interest in its own right to a wide range of persons and organisations.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 9 *Representational layout:* \$\$\$,\$\$\$,\$\$\$

Data domain:

Guide for use:

Verification rules: Australian dollars. Rounded to nearest whole dollar.

Collection methods:

Related data: relates to the data element Establishment type, version 1

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Community mental health care from 1/07/98 to

Comments:

Food supplies

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000240 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The cost of all food and beverages but not including kitchen expenses such as utensils, cleaning materials, cutlery and crockery. Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers.

Context: Health expenditure: this is a significant element of non-salary recurrent expenditure for most establishments within the data set and is thus required for any health expenditure analysis at the national level.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 9 *Representational layout:* \$\$\$,\$\$\$,\$\$\$

Data domain:

Guide for use:

Verification rules: Australian dollars. Rounded to nearest whole dollar.

Collection methods:

Related data: relates to the data element Establishment type, version 1

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Community mental health care from 1/07/98 to

Comments:

Full-time equivalent staff

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000252 *Version number:* 2

Data element type: DERIVED DATA ELEMENT

Definition: Full time equivalent staff units are the on-job hours paid for (including overtime) and hours of paid leave of any type for a staff member (or contract employee where applicable) divided by the number of ordinary time hours normally paid for a full-time staff member when on the job (or contract employee where applicable) under the relevant award or agreement for the staff member (or contract employee occupation where applicable). Hours of unpaid leave are to be excluded.

Contract staff employed through an agency are included where the contract is for the supply of labour (e.g. nursing) rather than of products (e.g. photocopier maintenance). In the former case, the contract would normally specify the amount of labour supplied and could be reported as full-time equivalent units.

Context: Health expenditure: to assist in analyses of the resource use and activity of institutional health care providers. Inclusion of these data, classified by staffing category, allows analysis of costs per unit of labour and analysis of staffing inputs against establishment outputs.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

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

Data domain: Average full-time equivalent staff units for each staffing category.

Guide for use: Staffing categories:

- C1.1 Salaried medical officers
- C1.2 Registered nurses
- C1.3 Enrolled nurses
- C1.4 Student nurses
- C1.5 Trainee / pupil nurses
- C1.6 Other personal care staff
- C1.7 Diagnostic and health professionals
- C1.8 Administrative and clerical staff
- C1.9 Domestic and other staff

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

If under the relevant award of agreement a full-time nurse is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time nurse who works 64 hours is 0.8. If a full-time nurse under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25.

Full-time equivalent staff (*continued*)

Guide for use (cont'd): Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each. (Salary costs should be apportioned on the same basis).

Verification rules:

Collection methods:

Related data: supersedes previous data element Total full-time equivalent staff, version 1

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Comments: This National Health Data Dictionary entry was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Indirect health care expenditure

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000326 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Expenditures on health care that cannot be directly related to programs operated by a particular establishment (that is, can only be indirectly related to particular establishments). To be provided at the State level but disaggregated into patient transport services, public health and monitoring services, central and statewide support services, central administrations and other indirect health care expenditure.

Context: Health expenditure: to improve and substantiate financial reporting in relation to indirect health care expenditure and assist in understanding differences in costs for similar establishments in different States and regions, due to differences in the extent to which support services and other services to residents/inpatients and outpatients of establishments may be provided by the establishment itself or by other bodies.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 9 *Representational layout:* \$\$\$,\$\$\$,\$\$\$

Data domain:

Guide for use: Indirect health care expenditure is to be reported separately for each of the following categories:

1. Patient transport services

Public or registered non-profit organisations which provide patient transport (or ambulance) for services associated with inpatient or residential episodes at residential establishments within the scope of this data set.

This category excludes patient transport services provided by other types of establishments (for example, public hospitals) as part of their normal services. This category includes centralised and statewide patient transport services (for example, Queensland Ambulance Transport Brigade) which operate independently of individual inpatient establishments.

2. Public health and monitoring services

Public or registered non-profit services and organisations with centralised, statewide or national public health or monitoring services. These include programs concerned primarily with preventing the occurrence of diseases and mitigating their effect, and includes such activities as mass chest X-ray campaigns, immunisation and vaccination programs, control of communicable diseases, ante-natal and post-natal clinics, preschool and school medical services, infant welfare clinics, hygiene and nutrition advisory services, food and drug inspection services, regulation of standards of sanitation, quarantine services, pest control, anti-cancer, anti-drug and anti-smoking campaigns and other programs to increase public awareness of disease symptoms and health hazards, occupational health services,

Indirect health care expenditure (*continued*)

Guide for use: (cont'd) Worksafe Australia, the Australian Institute of Health and Welfare and the National Health and Medical Research Council.

Included here would be child dental services comprising expenditure incurred (other than by individual establishments) or dental examinations, provision of preventive and curative dentistry, dental health education for infants and school children and expenditure incurred in the training of dental therapists.

3. Central and statewide support services

Public or registered services which provide central or statewide support services for residential establishments within the scope of this data set. These include central pathology services, central linen services and frozen food services and blood banks provided on a central or statewide basis such as Red Cross.

4. Central administrations

Expenditures relating to central health administration, research and planning for central and regional offices of State, Territory and Commonwealth health authorities and related departments (for example, the Department of Veterans' Affairs).

5. Other

Any other indirect health care expenditure as defined above not catered for in the above categories. This might include such things as family planning and parental health counselling services and expenditure incurred in the registration of notifiable diseases and other medical information.

Verification rules:

Collection methods:

Related data:

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Comments: Resources Working Party members were concerned about the possibility that double counting of programs at the hospital and again at the State level and were also concerned at the lack of uniformity between States. Where possible expenditure relating to programs operated by hospitals should be at the hospital level.

Interest payments

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000245 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Payments made by or on behalf of the establishment in respect of borrowings (e.g. interest on bank overdraft) provided the establishment is permitted to borrow. This does not include the cost of equity capital (i.e. dividends on shares) in respect of profit making private establishments.

Context: Health expenditure: this item has been retained in the data set because of its significance for the private sector. Private profit making establishments will seek to fund their operations either by loan borrowings (debt capital) or raising shares (equity capital). The cost of either can be significant, although the cost of the latter (that is, dividends on shares) would come out of profits.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 9 *Representational layout:* \$\$\$,\$\$\$,\$\$\$

Data domain:

Guide for use:

Verification rules: Australian dollars. Rounded to nearest whole dollar.

Collection methods:

Related data: relates to the data element Establishment type, version 1

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Community mental health care from 1/07/98 to

Comments: The item would not have been retained if the data set was restricted to the public sector. In some States, public hospitals may not be permitted to borrow funds or it may be entirely a State treasury matter, not identifiable by the health authority. Even where public sector establishment borrowings might be identified, this appears to be a sensitive area and also of less overall significance than in the private sector.

Medical and surgical supplies

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000239 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The cost of all consumables of a medical or surgical nature (excluding drug supplies) but not including expenditure on equipment repairs. Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers.

Context: Health expenditure: as for the data element Drug supplies this is a significant element of non-salary expenditure and national-level data on medical and surgical supplies is of considerable interest in its own right to a wide range of persons and organisations.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 9 *Representational layout:* \$\$\$,\$\$\$,\$\$\$

Data domain:

Guide for use:

Verification rules: Australian dollars. Rounded to nearest whole dollar.

Collection methods:

Related data: relates to the data element Establishment type, version 1

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Community mental health care from 1/07/98 to

Comments:

Non-salary operating costs

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000360 *Version number:* 1

Data element type: DERIVED DATA ELEMENT

Definition: Total expenditure relating to non-salary operating items.

Context: Health care: this data element is required to monitor trends of expenditure in the sector.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 9 *Representational layout:* \$\$\$,\$\$\$,\$\$\$

Data domain:

Guide for use: Report all expenditure in thousands of dollars (\$000's). Total is calculated from expenditure including: Payments to visiting medical officers, Superannuation employer contributions (including funding basis), Drug supplies; Medical and surgical supplies; Food supplies; Domestic services; Repairs and maintenance; Patient transport; Administrative expenses; Interest payments; Depreciation; Other recurrent expenditure.

Expenditure should include both the specific costs directly associated with the service and indirect costs for example personnel services.

Research and academic units that function as an integral part of ambulatory care should be reported against the appropriate service.

Verification rules:

Collection methods:

Related data:

- is calculated using Payments to visiting medical officers, version 1
- is calculated using Superannuation employer contributions (including funding basis), version 1
- is calculated using Drug supplies, version 1
- is calculated using Medical and surgical supplies, version 1
- is calculated using Food supplies, version 1
- is calculated using Domestic services, version 1
- is calculated using Repairs and maintenance, version 1
- is calculated using Patient transport, version 1
- is calculated using Administrative expenses, version 1
- is calculated using Interest payments, version 1
- is calculated using Depreciation, version 1
- is calculated using Other recurrent expenditure, version 1

Non-salary operating costs (*continued*)

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

Community mental health care from 1/07/98 to

Comments:

Other recurrent expenditure

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000247 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Other payments are all other recurrent expenditure not included elsewhere in any of the recurrent expenditure categories. Gross expenditure should be reported with no revenue offsets (except for inter-hospital transfers).

Context: Health expenditure: this category is required for balancing purposes and to capture all those additional expenditures which can be significant in aggregate.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 9 *Representational layout:* \$\$\$\$\$\$

Data domain:

Guide for use:

Verification rules: Australian dollars. Rounded to nearest whole dollar.

Collection methods:

Related data: relates to the data element Establishment type, version 1

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

Institutional health care from 1/07/89 to

Community mental health care from 1/07/98 to

Comments:

Patient transport

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000243 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The direct cost of transporting patients excluding salaries and wages of transport staff.

Context: Health expenditure: considered to be a significant element of non-salary recurrent expenditure for many establishments within the data set and is thus required for any health expenditure analysis at the national level.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 9 *Representational layout:* \$\$\$,\$\$\$,\$\$\$

Data domain:

Guide for use:

Verification rules: Australian dollars. Rounded to nearest whole dollar.

Collection methods:

Related data: relates to the data element Establishment type, version 1

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

Institutional health care from 1/07/89 to

Community mental health care from 1/07/98 to

Comments:

Payments to visiting medical officers

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000236 *Version number:* 1

Data element type: DATA ELEMENT

Definition: All payments made by an institutional health care establishment to visiting medical officers for medical services provided to hospital (public) patients on an honorary, sessionally paid, or fee for service basis.

A visiting medical officer is a medical practitioner appointed by the hospital board to provide medical services for hospital (public) patients on an honorary, sessionally paid, or fee for service basis. This category includes the same Australian Standard Classification of Occupations codes as the salaried medical officers category.

Context: Health expenditure: this is a significant element of expenditure for many hospitals (although not for other establishments) and needed for health financing and health expenditure analysis at the national level. Any analysis of health expenditures at the national level would tend to break down if significant components of expenditure were not available.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: Min. 1 Max. 9 *Representational layout:* \$\$\$,\$\$\$,\$\$\$

Data domain:

Guide for use:

Verification rules: Australian dollars. Rounded to nearest whole dollar.

Collection methods:

Related data: relates to the data element Establishment type, version 1

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

Institutional health care from 1/07/89 to

Community mental health care from 1/07/98 to

Comments: Although accepting the need to include visiting medical officer payments, the Resources Working Party decided not to include data on visiting medical officer services (whether hours or number of sessions or number of services provided) due to collection difficulties and the perception that use of visiting medical officers was purely a hospital management issue.

Repairs and maintenance

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000242 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The costs incurred in maintaining, repairing, replacing and providing additional equipment, maintaining and renovating building and minor additional works. Expenditure of a capital nature should not be included here. Do not include salaries and wages of repair and maintenance staff. Gross expenditure should be reported with no revenue offsets (except for inter-hospital transfers).

Context: Health expenditure: this is a significant element of non-salary recurrent expenditure for most establishments within the data set and is thus required for any health expenditure analysis at the national level.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 9 *Representational layout:* \$\$\$,\$\$\$,\$\$\$

Data domain:

Guide for use:

Verification rules: Australian dollars. Rounded to nearest whole dollar.

Collection methods:

Related data: relates to the data element Establishment type, version 1

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

Institutional health care from 1/07/89 to

Community mental health care from 1/07/98 to

Comments:

Salaries and wages

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000254 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Salary and wage payments for all employees of the establishment (including contract staff employed by an agency, provided staffing (ME) data is also available). This is to include all paid leave (recreation, sick and long-service) and salary and wage payments relating to workers compensation leave for the following staffing categories (see below).

Generally, salary data by staffing categories should be broadly consistent with full-time equivalent staffing numbers. Where staff provide services to more than one hospital, their salaries should be apportioned between all hospitals to whom services are provided on the basis of hours worked in each hospital.

Salary payments for contract staff employed through an agency should be included under salaries for the appropriate staff category provided they are included in full-time equivalent staffing. If they are not salary, payments should be shown separately.

Context: Health expenditure: salaries and wages invariably constitute the major component of recurrent and, indeed, total expenditure for the establishments forming part of this data set and are vital to any analysis of health expenditure at the national level. The categories correspond with those relating to full-time equivalent staffing which is a requirement for any proper analysis of average salary costs.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 9 *Representational layout:* \$\$\$\$\$\$

Data domain: Expenditure for each staffing category.

Guide for use: Figures should be supplied for each of the staffing categories:

- C1.1 Salaried medical officers
- C1.2 Registered nurses
- C1.3 Enrolled nurses
- C1.4 Student nurses
- C1.5 Trainee / pupil nurses
- C1.6 Other personal care staff
- C1.7 Diagnostic and health professionals
- C1.8 Administrative and clerical staff
- C1.9 Domestic and other staff

Verification rules:

Salaries and wages (*continued*)

Collection methods: For contract staff, see comments under the data element Total full-time equivalent staff. Salary data for contract staff, provided the contract is for the supply of labour (e.g. nursing) rather than products (e.g. photocopier maintenance), should be shown under the appropriate staff salary category provided that corresponding staffing (full-time equivalent) data is available. If not, it should be shown separately.

Related data: relates to the data element Establishment type, version 1

relates to the data element Full-time equivalent staff, version 2

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

Institutional health care from 1/07/89 to

Community mental health care from 1/07/98 to

Comments:

Superannuation employer contributions (including funding basis)

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000237 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Superannuation employer contributions

Contributions paid or (for an emerging cost scheme) that should be paid (as determined by an actuary) on behalf of establishment employees either by the establishment or a central administration such as a State health authority, to a superannuation fund providing retirement and related benefits to establishment employees.

Funding basis

The following different funding bases are identified:

- paid by hospital to fully funded scheme;
- paid by Commonwealth government or State government to fully funded scheme; and
- unfunded or emerging costs schemes where employer component is not presently funded.

Fully funded schemes are those in which employer and employee contributions are paid into an invested fund. Benefits are paid from the fund. Most private sector schemes are fully funded.

Emerging cost schemes are those in which the cost of benefits is met at the time a benefit becomes payable; that is, there is no ongoing invested fund from which benefits are paid. The Commonwealth superannuation fund is an example of this type of scheme as employee benefits are paid out of general revenue.

Context: Health expenditure: superannuation employer contributions are a significant element of establishment expenditure and, as such, are required for health expenditure analysis at the national level.

The funding basis is required for cost comparison purposes particularly in the case of unfunded or emerging cost schemes where no actual contribution is being presently made but ultimately employer liability will have to be funded.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 9 *Representational layout:* \$\$\$\$\$\$

Data domain:

Guide for use:

Verification rules: Australian dollars. Rounded to nearest whole dollar.

Superannuation employer contributions (including funding basis) (*continued*)

Collection methods:

Related data: relates to the data element Establishment type, version 1

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

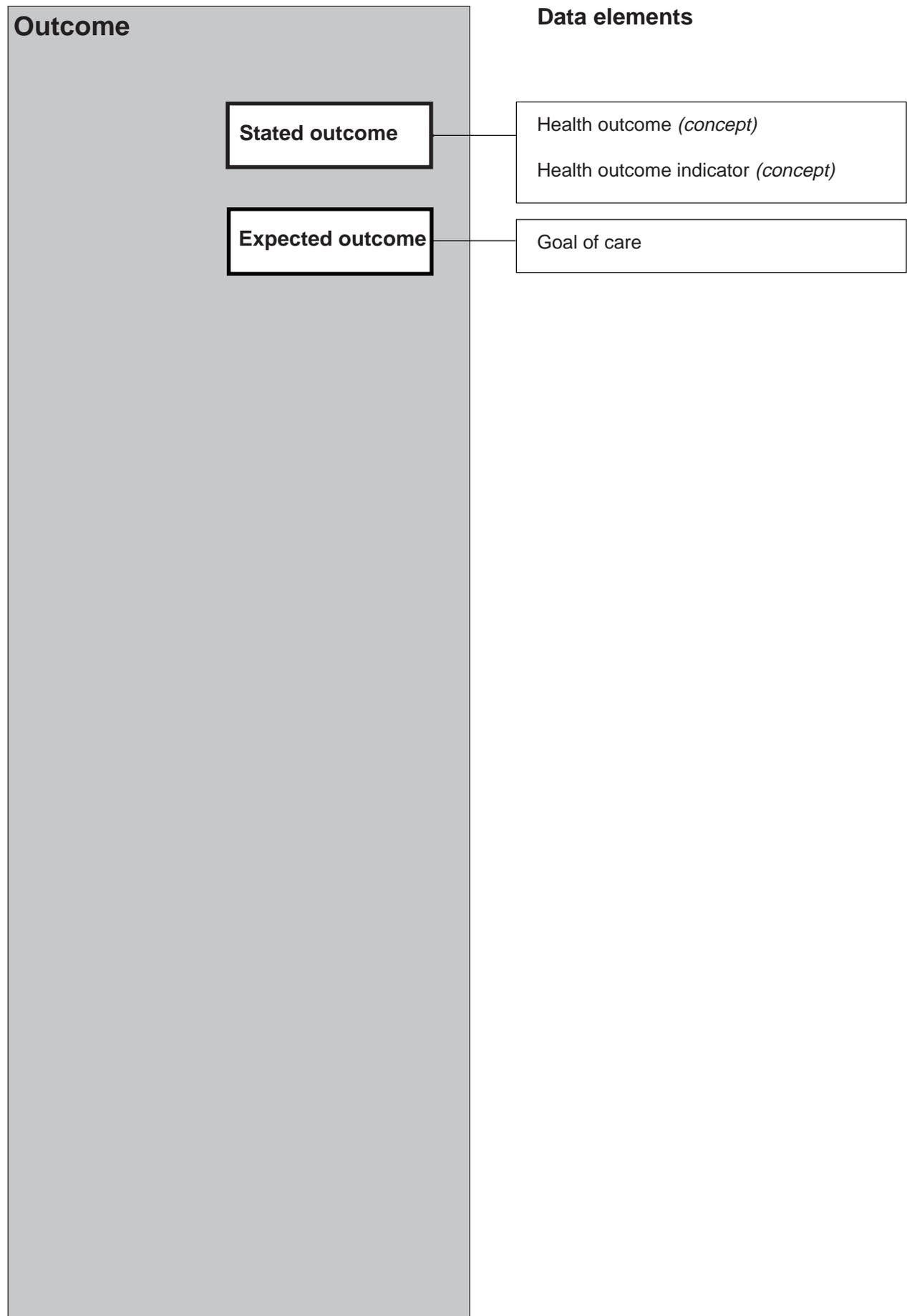
Institutional health care	from 1/07/89 to
Community mental health care	from 1/07/98 to

Comments: The definition specifically excludes employee superannuation contributions (not a cost to the establishment) and superannuation final benefit payments.

In private enterprise some superannuation schemes are partially funded but this is considered too complex a distinction for national minimum data sets.

It is noted that the emergence of salary sacrifice schemes allows employees to forego salary for higher superannuation contributions. If these become significant, national minimum data sets may have to take them into account at a future stage.

National Health Information Model entities



Health outcome

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000062 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

Definition: A change in the health of an individual, or a group of people or a population, which is wholly or partially attributable to an intervention or a series of interventions

Context: Institutional and non-institutional health care

Relational and representational attributes

Datatype: *Representational form:*

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

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data:

Administrative attributes

Source document:

Source organisation: National Health Information Management Group

National minimum data sets:

Comments:

Health outcome indicator

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000063 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

Definition: A statistic or other unit of information which reflects, directly or indirectly, the effect of an intervention, facility, service or system on the health of its target population, or the health of an individual.

- A generic indicator provides information on health, perceived health or a specific dimension of health using measurement methods that can be applied to people in any health condition.
- A condition-specific indicator provides information on specific clinical conditions or health problems, or aspects of physiological function pertaining to specific conditions or problems.

Epidemiological terminology

- An association exists between two phenomena (such as an intervention and a health outcome) if the occurrence or quantitative characteristics of one of the phenomena varies with the occurrence or quantitative characteristics of the other.
- One phenomenon is attributable to another if there is a casual link between the phenomena. Attribution depends upon the weight of evidence for causality.
- Association is necessary (but not sufficient) for attribution. Associations may be fortuitous or causal. The term relationship is to be taken as synonymous with association.

Context: Institutional and non-institutional health care

Relational and representational attributes

Datatype: *Representational form:*

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

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data:

Administrative attributes

Source document:

Source organisation: National Health Information Management Group

National minimum data sets:

Comments:

Goal of care

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000111 *Version number:* 2

Data element type: DATA ELEMENT

Definition: The goal or expected outcome of a plan of care, negotiated by the service provider and recipient, which outlines the overall aim of actions planned by a community service and relates to a person's health need. This goal reflects a total care plan and takes into account the possibility that a range of community services may be provided within a specified time frame.

Context: This item focuses on the broad goal which the person and services provider hope to achieve within an expected time period and takes into account the intervention or services provided by a range of community services.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

01	Well person for preventative/maintenance/health promotion program;
02	Person will make a complete recovery;
03	Person will not make a complete recovery; but will rehabilitate to a state where formal on-going service is no longer required;
04	Person has a long-term care need and the goal is aimed at on-going support to maintain at home;
05	Person in end-stage of illness the goal is aimed at support to stay at home in comfort and dignity and facilitation of choice of where to die;
06	Person is unable to remain at home for extended period and goal is aimed at institutionalisation at a planned and appropriate time;
07	For assessment only/not applicable.

Guide for use:

- GOAL 1 service recipients are those making contact with the health service primarily as a part of a preventative/maintenance health promotion program. This means they are well and do not require care for established health problems. They include well antenatal persons attending or being seen by the service for screening or health education purposes.

- GOAL 2 describes those persons whose condition is self-limiting and from which complete recovery is anticipated, or those with established or long term health problems who are normally independent in their management.

Goal 2 service recipient includes:

- post surgical or acute medical service recipients whose care at home is to facilitate convalescence. Such admissions to home care occur as a result of early discharge from hospital; post-surgical complication such as wound

Goal of care (*continued*)

Guide for use (cont'd): infection; or because the person is at risk during the recovery phase and requires surveillance for a limited period;

- persons recovering from an acute illness and referred from the general practitioner or other community based facility;

- persons with disability or established health problem normally independent of health services, and currently recovering from an acute condition or illness as above.

3. GOAL 3 refers to those service recipients whose care plan is aimed at returning them to independent functioning at home either through self-care or with informal assistance, such that formal services will be discontinued. The distinguishing characteristic of this group is that complete recovery is not expected but some functional gain may be possible. Further, the condition is not expected to deteriorate rapidly or otherwise cause the client to be at risk without contact or surveillance from the community service.

4. GOAL 4 refers to those service recipients whose health problem/condition is not expected to resolve and who will require ongoing maintenance care from the nursing service. Such clients are distinguished from those in Goal 3 in that their condition is of an unknown or long-term nature and not expected to cause death in the foreseeable future. They may require therapy for restoration of function initially and intermittently, and may also have intermittent admissions for respite. However, the major part of their care is planned to be at home.

5. GOAL 5 refers to persons whose focus of care is palliation of symptoms and facilitation of the choice to die at home.

6. GOAL 6 includes persons who have a limited ability to remain at home because of their intensive care requirements and the inability of formal and informal services to meet these needs. Admission to institutional care is therefore a part of the care planning process and the timing dependent upon the capacity and/or wish to remain at home. The distinguishing feature of this group is that the admission is not planned to be an intermittent event to boost the capacity for home care but is expected to be of a more permanent (or indeterminate) nature.

- Excluded from this group are persons with established health problems or permanent disability, if the contact is related to the condition. For example, persons with diabetes and in a diabetes program would be included in Goal 3; however, such persons would be included in goal 6 if the contact with the service is not related to an established health problem but is primarily for preventative/maintenance care as described above.

7. GOAL 7 service recipients are those for whom the reason for the visit is to undertake an assessment. This may include clients in receipt of a Domiciliary Nursing Care Benefit (DNCB) for whom the purpose of the visit is to determine ongoing DNCB eligibility and requirements for care. Implicit in this visit is review of the person's health status and circumstances, to ensure that their ongoing support does not place them or their carer at avoidable risk.

Goal of care (*continued*)

Verification rules: Only one option is permissible and where Code 7 is selected, Code 9 must be used in Nursing interventions.

Collection methods: At time of formal review of the client, the original Goal of care should be retained and not over-written by the system. The goal of care relates to the episode bounded by the Date of first contact with community nursing service and Date of last contact and in this format provides a focussing effect at the time of planning for care.

Related data: supersedes previous data element Nursing goal, version 1
relates to the data element Date of first contact, version 2
relates to the data element Nursing diagnosis, version 2
relates to the data element Nursing interventions, version 2
relates to the data element Date of last contact, version 2

Administrative attributes

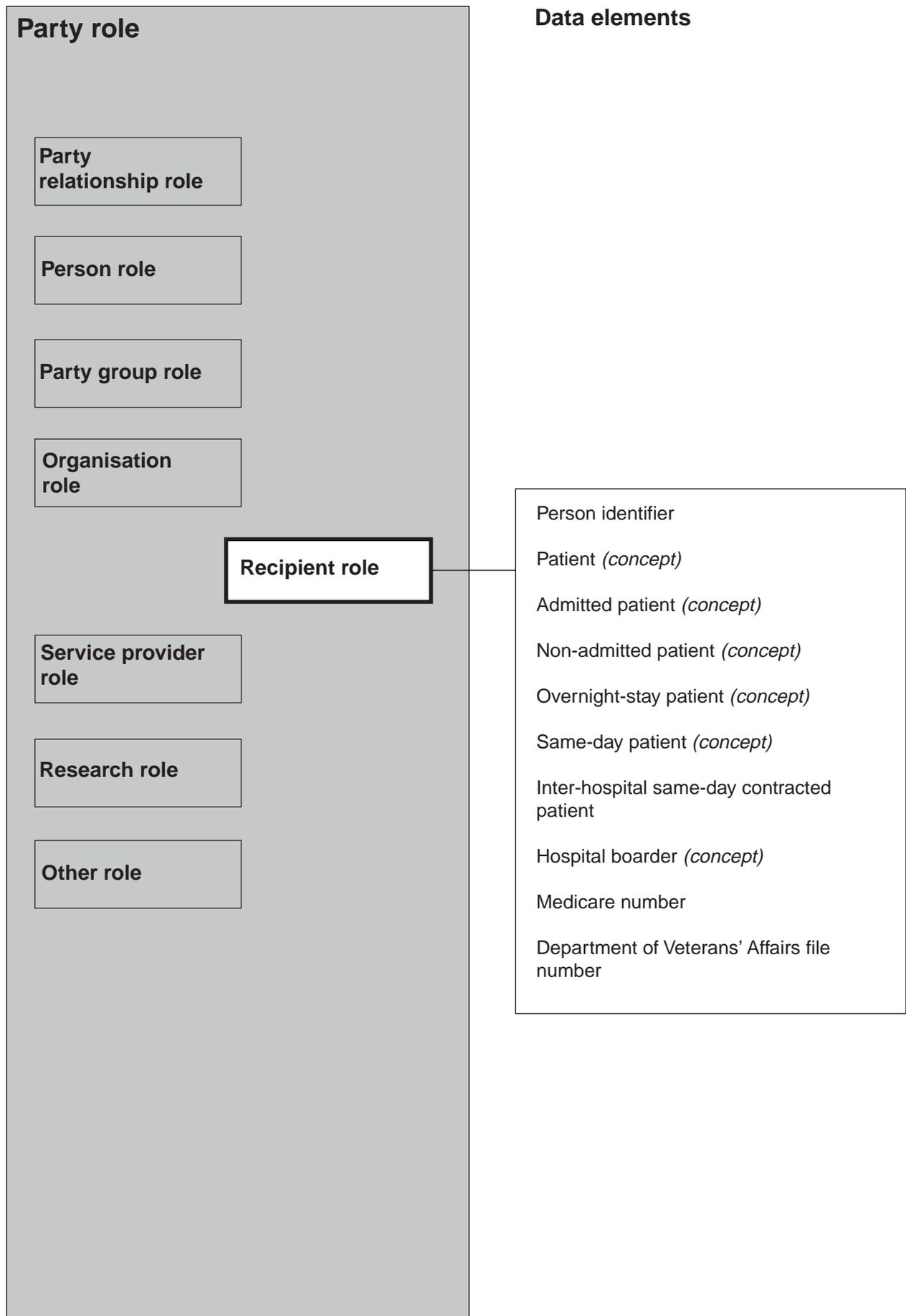
Source document:

Source organisation: Australian Council of Community Nursing Services

National minimum data sets:

Comments: Agencies who had previously implemented this item should note changes to the code set in data domain.

National Health Information Model entities



Person identifier

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000127 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Person identifier unique within establishment or agency.

Context: This item could be used for editing at the establishment or collection authority level and, potentially, for episode linkage. There is no intention that this item would be available beyond collection authority level.

Relational and representational attributes

Datatype: Alphanumeric *Representational form:* CODE

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

Data domain:

Guide for use: Individual establishments or collection authorities may use their own alphabetic, numeric or alphanumeric coding systems.

Verification rules:

Collection methods:

Related data:

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

Institutional health care from 1/07/89 to

Institutional mental health care from 1/07/97 to

Perinatal from 1/07/97 to

Community mental health care from 1/07/2000 to

Palliative care from 1/07/2000 to

Comments: For institutional health care statistics, person identifier is used in conjunction with other data elements recording individual episodes of care or events. To date, there has been limited development of patient-based data ie. linking data within hospital morbidity collections about all episodes of care for individuals.

Patient

Admin. status: CURRENT 1/07/95

Identifying and definitional attributes

Knowledgebase ID: 000117 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

Definition: A patient is a person for whom a hospital accepts responsibility for treatment and/or care. There are two categories of patient, admitted and non-admitted patients. Boarders are not patients.

Context: Institutional health care

Relational and representational attributes

Datatype: *Representational form:*

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

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data: relates to the data element concept Admitted patient, version 1

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Comments: While the concept of a person for whom a service provider accepts responsibility for treatment or care is also applicable to non-institutional health care and to welfare services, different terminology is often used in these other care settings e.g. client, resident.

Admitted patient

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000011 *Version number:* 2

Data element type: DATA ELEMENT CONCEPT

Definition: An admitted patient is a patient who undergoes a hospital's formal admission process as either an overnight stay patient or a same-day patient.

Context: Institutional health care.

Relational and representational attributes

Datatype: *Representational form:*

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

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data: supersedes previous data element Admitted patient, version 1
relates to the data element Patient days, version 2
relates to the data element Date of change to qualification status, version 1
relates to the data element Qualification status, version 1
relates to the data element Number of acute (qualified)/unqualified days for newborns, version 1
relates to the data element Type of episode of care, version 3

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

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

- is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient;
- is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Health Minister for the purpose of the provision of special care;

Admitted patient (*continued*)

Comments (cont'd): - 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

Admin. status: CURRENT 1/07/94

Identifying and definitional attributes

Knowledgebase ID: 000104 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

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

There are three categories of non-admitted patient:

- emergency department patient

- outpatient

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

Context: Institutional health care

Relational and representational attributes

Datatype: *Representational form:*

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

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data: relates to the data element concept Patient, version 1

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Comments:

Overnight-stay patient

Admin. status: CURRENT 1/07/94

Identifying and definitional attributes

Knowledgebase ID: 000116 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

Definition: A patient who, following a clinical decision, receives hospital treatment for a minimum of one night i.e. who is admitted to and separated from the hospital on different dates.

Context: Institutional health care

Relational and representational attributes

Datatype: *Representational form:*

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

Data domain:

Guide for use: An overnight-stay patient of a hospital (originating hospital) who attends another hospital (the destination hospital) for a same-day procedure is to be regarded by the originating hospital as an overnight-stay patient, as if the patient had not left for the same-day procedure. For reporting purposes, the procedure is regarded as part of the overnight-stay episode at the originating hospital. The destination hospital must record the patient as a 'contracted same-day patient', thus distinguishing that patient from other same-day patients who were not simultaneously overnight-stay patients at another hospital. Refer to the data element Intended length of hospital stay.

An overnight-stay patient in one hospital cannot be concurrently an overnight-stay patient in another hospital. Such a patient must be discharged from one and admitted to the other on each occasion of transfer.

Treatment provided to an intended same-day patient who is subsequently classified as an overnight-stay patient shall be regarded as part of the overnight episode.

A non-admitted (emergency/outpatient) service provided to a patient who is subsequently classified as an admitted patient shall be regarded as part of the admitted episode. Any occasion of service should be recorded and identified as part of the admitted patient's episode of care.

The definition of an overnight-stay patient excludes patients who leave of their own accord, die or are transferred on their first day in the hospital.

Verification rules:

Collection methods:

Related data: relates to the data element concept Admitted patient, version 1

Administrative attributes

Source document:

Source organisation: National Health Data Committee

Overnight-stay patient (*continued*)

National minimum data sets:

Institutional health care

from 1/07/89 to

Comments:

Same-day patient

Admin. status: CURRENT 1/07/94

Identifying and definitional attributes

Knowledgebase ID: 000146 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

Definition: A same-day patient is a patient who is admitted and separates on the same date, and who meets one of the following minimum criteria:

- That the patient receive Same-day Surgical and Diagnostic Services as specified in bands 1A, 1B, 2, 3, and 4 but excluding uncertified type C Professional Attention Procedures within the Health Insurance Basic Table as defined in s.4 (1) of the National Health Act 1953 (C'wlth); or
- That the patient receive type C Professional Attention Procedures as specified in the Health Insurance Basic Table as defined in s.4 (1) of the National Health Act 1953 (C'wlth) with accompanying certification from a medical practitioner that an admission was necessary on the grounds of the medical condition of the patient or other special circumstances that relate to the patient.

Context: Institutional health care

Relational and representational attributes

Datatype: *Representational form:*

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

Data domain:

Guide for use: Same-day patients may be either intended to be separated on the same day, or intended overnight-stay patients who left of their own accord, died or were transferred on their first day in the hospital.

Treatment provided to an intended same-day patient who is subsequently classified as an overnight-stay patient shall be regarded as part of the overnight episode.

Non-admitted (emergency or outpatient) services provided to a patient who is subsequently classified as an admitted patient shall be regarded as part of the admitted episode. Any occasion of service should be recorded and identified as part of the admitted patient's episode of care.

Data on same-day patients are derived by a review of admission and separation dates.

Verification rules:

Collection methods:

Related data: relates to the data element concept Admitted patient, version 1

Administrative attributes

Source document:

Source organisation: National Health Data Committee

Same-day patient (*continued*)

National minimum data sets:

Institutional health care

from 1/07/89 to

Comments:

Inter-hospital same-day contracted patient

Admin. status: CURRENT 1/07/94

Identifying and definitional attributes

Knowledgebase ID: 000079 *Version number:* 1

Data element type: DATA ELEMENT

Definition: An admitted same-day patient whose treatment and/or care is provided under a specific arrangement with another hospital at which the patient is an admitted patient.

Context: Institutional health care: to identify patients receiving services that have been contracted between hospitals. This item will assist in the analysis of patterns of health care delivery and funding.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:
1 Inter-hospital same-day contracted patient
2 Other

Guide for use: A specific arrangement should apply (either written or verbal) whereby one hospital contracts with another hospital for the provision of specific services. The arrangement may be between any combination of hospital; for example, public to public, public to private, private to private, or private to public. For purposes of this definition, current financial arrangements for compensable or eligible Veterans Affairs' patients are not to be considered as contracted or special arrangements.

Verification rules:

Collection methods: All services provided at both the originating and destination hospitals should be recorded and reported by the originating hospital. The destination hospital should record the same-day admission as an 'Inter-hospital same-day contracted patient' so that these services can be identified in the various statistics produced about hospital activity. These patients will be able to be identified in retrospect using the following data elements:

1. Source of referral = 1 transfer from another hospital.
2. Mode of separation = 1 transfer to another hospital.
3. Inter-hospital same-day contracted patient = 1 contracted.

Related data:

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Comments:

Hospital boarder

Admin. status: CURRENT 1/07/94

Identifying and definitional attributes

Knowledgebase ID: 000065 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

Definition: A person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care.

Context: Institutional health care

Relational and representational attributes

Datatype: *Representational form:*

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

Data domain:

Guide for use: A boarder thus defined is not admitted to the hospital. However, a hospital may register a boarder.

Babies in hospital at age 9 days or less cannot be boarders. They are admitted patients with each day of stay deemed to be either a qualified or unqualified day.

Verification rules:

Collection methods:

Related data:

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Comments:

Medicare number

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000091 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Personal identifier allocated by the Health Insurance Commission to eligible persons under the Medicare scheme.

Context: Medicare utilisation statistics and institutional health care.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 11 *Max.* 11 *Representational layout:* NNNNNNNNNNNN

Data domain: Full Medicare number for an individual (ie. family number plus person number)

Guide for use:

Verification rules:

Collection methods:

Related data:

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Comments: Under Medicare, each eligible family in the population is assigned a unique identifying number. This number, together with age and sex, provides an essentially unique identifier.

Department of Veterans' Affairs file number

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000204 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The Department of Veterans' Affairs file number of the person.

Context: Institutional health care: this number must be recorded by a service provider each time a service is provided to a person who holds the entitlement for reimbursement purposes.

Relational and representational attributes

Datatype: Alphanumeric *Representational form:* IDENTIFICATION NUMBER

Field size: *Min.* 7 *Max.* 7 *Representational layout:* AAANNNN

Data domain:

Guide for use: The file reference is a seven digit identifier that can have a State code (N,V,Q,S,W,T) included, and in some circumstances a file type code is added. ACT is included in NSW (N) and NT with SA (S).

Individuals are identified by an alphanumeric code at the end of the file number. A veteran's spouse and children have the same file number but are identified within the DVA Client Database with a segment link or suffix. The segment link and suffix are different and can change. For example, the suffix usually changes when a wife becomes a widow.

Changes to the information system in the Department of Veteran's Affairs may permit the identification of all individual States and Territories in the future.

Verification rules:

Collection methods:

Related data:

Administrative attributes

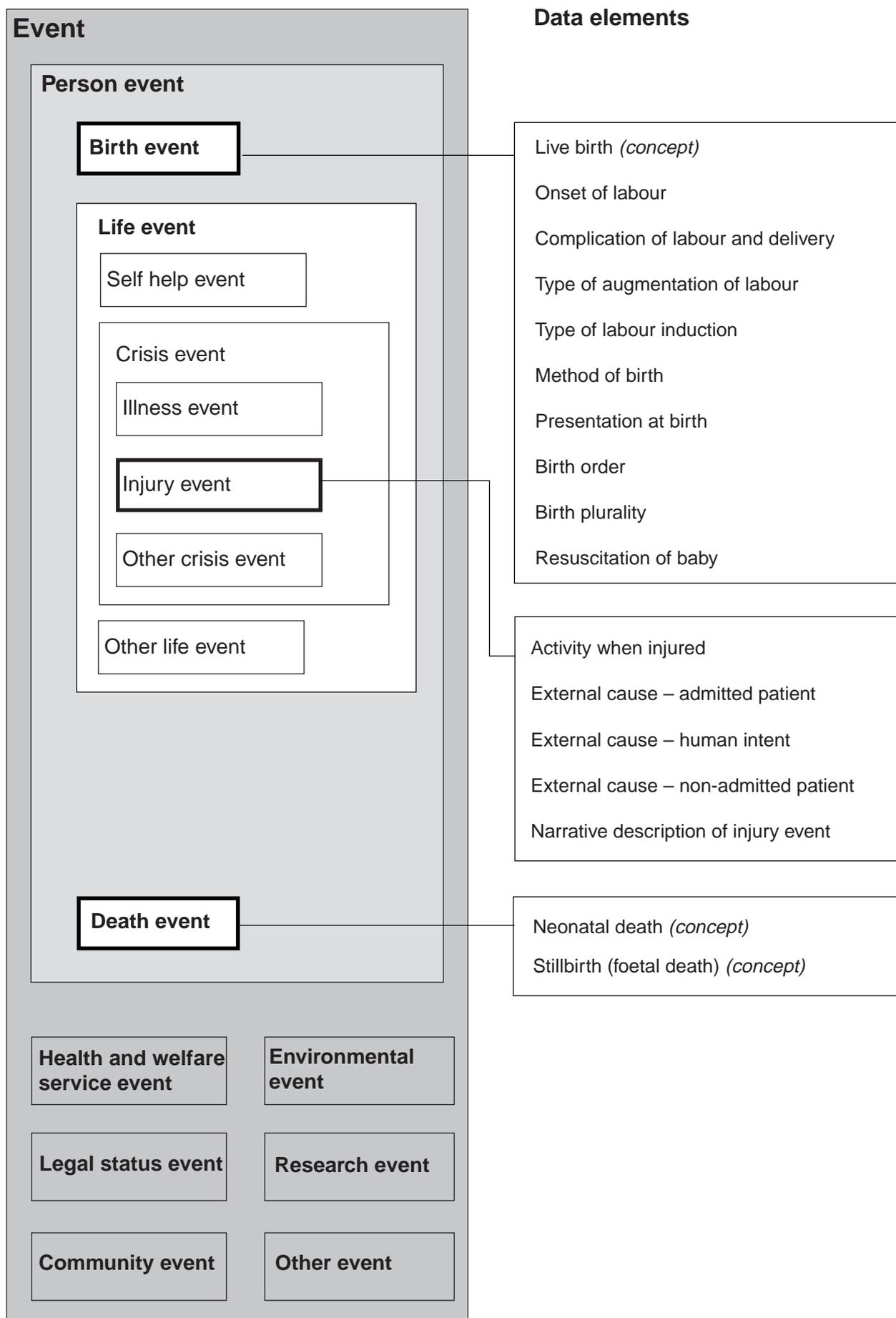
Source document:

Source organisation: Department of Veterans' Affairs, National Health Data Committee

National minimum data sets:

Comments:

National Health Information Model entities



Live birth

Admin. status: CURRENT 1/07/94

Identifying and definitional attributes

Knowledgebase ID: 000083 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

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

Context: Perinatal

Relational and representational attributes

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 Development Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Perinatal from 1/07/97 to

Comments:

Onset of labour

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000113 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Manner in which labour started.

Context: Perinatal statistics: how labour commenced is closely associated with type of delivery and maternal and neonatal morbidity. Induction rates vary for maternal risk factors and obstetric complications and are important indicators of obstetric intervention.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

1	Spontaneous
2	Induced
3	No labour
9	Not stated

Guide for use: 'No labour' can only be associated with caesarean section.

Verification rules:

Collection methods:

Related data: is used in conjunction with Type of labour induction, version 1

Administrative attributes

Source document:

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Perinatal from 1/07/97 to

Comments:

Complication of labour and delivery

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000027 *Version number:* 2

Data element type: DATA ELEMENT

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

Context: Perinatal 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 implemented ICD-10-AM from 1 July 1998. Other States will implement ICD-10-AM from 1 July 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

supersedes previous data element Complication of labour and delivery – ICD-9-CM code, version 1

is used in conjunction with Postpartum complication, version 2

Administrative attributes

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

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Comments:

Type of augmentation of labour

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000167 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Methods used to assist progress of labour.

Context: Neonatal care: type of augmentation determines the progress and duration of labour and may influence the method of delivery and the health status of the baby at birth.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain: 0 None

- 1 Oxytocin
- 2 Prostaglandins
- 3 Artificial rupture of membranes (ARM)
- 4 Other

Guide for use: More than one method of augmentation can be recorded, except where 0=none applies.

Verification rules:

Collection methods:

Related data: is used in conjunction with Onset of labour, version 1
is used in conjunction with Type of labour induction, version 1

Administrative attributes

Source document:

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Comments:

Type of labour induction

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000171 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Methods used to induce labour.

Context: Perinatal statistics: type of induction determines the progress and duration of labour and may influence the method of delivery and the health status of the baby at birth.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

0	None
1	Oxytocin
2	Prostaglandins
3	Artificial rupture of membranes (ARM)
4	Other

Guide for use: More than one method of induction can be recorded, except where 0=none applies.

Verification rules:

Collection methods:

Related data: is used in conjunction with Onset of labour, version 1
is used in conjunction with Type of augmentation of labour, version 1

Administrative attributes

Source document:

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Comments:

Method of birth

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000093 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The method of complete expulsion or extraction from its mother of a product of conception.

Context: Perinatal statistics: the method of delivery may affect the health status of the mother and the baby at birth and during the postpartum period.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

1	Spontaneous vaginal
2	Forceps (assisted vaginal birth)
3	Vaginal breech
4	Caesarean section
5	Vacuum extraction
8	Other
9	Not stated

Guide for use: In a vaginal breech with forceps to the aftercoming head, code as vaginal breech.

Verification rules:

Collection methods:

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

Administrative attributes

Source document:

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Perinatal from 1/07/97 to

Comments:

Presentation at birth

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000133 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Presenting part of the foetus (at lower segment of uterus) at birth.

Context: Perinatal statistics: presentation types other than vertex are associated with higher rates of caesarean section, instrumental delivery, perinatal mortality and neonatal morbidity.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

1	Vertex
2	Breech
3	Face
4	Brow
8	Other
9	Not stated

Guide for use:

Verification rules:

Collection methods:

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

Administrative attributes

Source document:

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Comments:

Birth order

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000019 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The order of each baby of a multiple birth.

Context: Perinatal statistics: required to analyse pregnancy outcome according to birth order and identify the individual baby resulting from a multiple birth pregnancy. Multiple births have higher risks of perinatal mortality and morbidity. Multiple birth pregnancies are often associated with obstetric complications, labour and delivery complications, higher rates of neonatal morbidity, low birthweight, and a higher perinatal death rate.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

1	Singleton or first of a multiple birth
2	Second of a multiple birth
3	Third of a multiple birth
4	Fourth of a multiple birth
5	Fifth of a multiple birth
6	Sixth of a multiple birth
8	Other
9	Not stated

Guide for use:

Verification rules:

Collection methods:

Related data: is a qualifier of Birth plurality, version 1

Administrative attributes

Source document:

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Perinatal from 1/07/97 to

Comments:

Birth plurality

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000020 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The total number of births resulting from this pregnancy.

Context: Perinatal statistics: multiple pregnancy increases the risk of complications during pregnancy, labour and delivery and is associated with higher risk of perinatal morbidity and mortality.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

1	Singleton
2	Twins
3	Triplets
4	Quadruplets
5	Quintuplets
6	Sextuplets
8	Other
9	Not stated

Guide for use: Plurality of a pregnancy is determined by the number of live births or by the number of foetuses that remain in utero at 20 weeks gestation and that are subsequently born separately. In multiple pregnancies, or if gestational age is unknown, only live births of any birthweight or gestational age, or foetuses weighing 400 g or more, are taken into account in determining plurality. Foetuses aborted before 20 completed weeks or foetuses compressed in the placenta at 20 or more weeks are excluded.

Verification rules:

Collection methods:

Related data: is qualified by Birth order, version 1

Administrative attributes

Source document:

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Perinatal from 1/07/97 to

Comments:

Resuscitation of baby

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000145 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Active measures taken immediately after birth to establish independent respiration and heart beat, or to treat depressed respiratory effort and to correct metabolic disturbances.

Context: Perinatal statistics: required to analyse need for resuscitation after complications of labour and delivery and to evaluate level of services needed for different birth settings.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

1	None
2	Suction only
3	Oxygen therapy only
4	Intermittent positive pressure respiration (IPPR) through bag and mask
5	Endotracheal intubation and IPPR
6	External cardiac massage and ventilation
8	Other

Guide for use:

Verification rules:

Collection methods:

Related data: is used in conjunction with Status of the baby, version 1
is used in conjunction with Apgar score at 1 minute, version 1
is used in conjunction with Apgar score at 5 minutes, version 1

Administrative attributes

Source document:

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Comments:

Activity when injured

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000002 *Version number:* 1

Data element type: DATA ELEMENT

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

1	Sports activity
2	Leisure activity
3	Working for income (include travel to and from work)
4	Other type of work (include unpaid housework)
5	Resting, sleeping, eating, other personal activity
6	Being nursed or cared for
7	Engaged in formal educational activity (as a student)
8	Other specified activity
9	Unspecified activity

Guide for use: Admitted patients: add the appropriate code as a fifth character when using ICD-10-AM external cause codes within the range V01 – Y34.

Non-admitted patients: 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.

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

Verification rules:

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 a qualifier of Narrative description of injury event, version 1
- is used in conjunction with Nature of main injury – non-admitted patient, version 1
- is used in conjunction with Bodily location of main injury, version 1

Activity when injured (*continued*)

Administrative attributes

Source document:

Source organisation: National Injury Surveillance Unit

National minimum data sets:

Institutional health care from 1/07/89 to

Injury surveillance from 1/07/89 to

Comments:

External cause – admitted patient

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000053 *Version number:* 4

Data element type: DATA ELEMENT

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

Context: 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

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

Data domain: ICD-10-AM

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).

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

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

Collection methods:

Related data: is used in conjunction with Activity when injured, version 1
 is used in conjunction with Place of occurrence of external cause, version 2
 supersedes previous data element External cause – admitted patient – ICD-9-CM code, version 3
 is used in conjunction with Principal diagnosis, version 3
 is used in conjunction with Additional diagnosis, version 4

External cause – admitted patient (*continued*)

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 Standards for Injury Surveillance Advisory Group

National minimum data sets:

Institutional health care from 1/07/89 to

Injury surveillance from 1/07/89 to

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

External cause – human intent

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000382 *Version number:* 4

Data element type: DATA ELEMENT

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

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

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

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

Verification rules:

Collection methods:

Related data: supersedes previous data element External cause – human intent, version 3

is used in conjunction with Place of occurrence of external cause of injury – non-admitted patient, version 3

is used in conjunction with Narrative description of injury event, version 1

External cause – human intent (*continued*)

Related data (cont'd): is used in conjunction with Nature of main injury – non-admitted patient, version 1

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

is used in conjunction with Activity when injured, version 1

Administrative attributes

Source document:

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

National minimum data sets:

Injury surveillance from 1/07/89 to

Comments:

External cause – non-admitted patient

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000381 *Version number:* 4

Data element type: DATA ELEMENT

Definition: Event, circumstance or condition associated with the occurrence of injury, poisoning or adverse effect.

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

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

01	Motor vehicle – driver
02	Motor vehicle – passenger or unspecified occupant
03	Motorcycle – driver
04	Motorcycle – passenger or unspecified
05	Pedal cyclist or pedal cycle passenger
06	Pedestrian
07	Other or unspecified transport-related circumstance
08	Horse-related (includes fall from, struck or bitten by)
09	Fall – low (on same level or < 1 metre or no information on height)
10	Fall – high (drop of 1 metre or more)
11	Drowning, submersion – swimming pool
12	Drowning, submersion – other than swimming pool (excludes drowning associated with water craft [07])
13	Other threat to breathing (including strangling and asphyxiation)
14	Fire, flames, smoke
15	Hot drink, food, water, other fluid, steam, gas or vapour
16	Hot object or substance, not otherwise specified
17	Poisoning – drugs or medicinal substance
18	Poisoning – other substance
19	Firearm
20	Cutting, piercing object
21	Dog-related
22	Animal-related (excluding Horse [08] and Dog [21])
23	(deleted)
24	Machinery in operation
25	Electricity
26	Hot conditions (natural origin) sunlight

External cause – non-admitted patient (*continued*)

<i>Data domain (cont'd):</i>	27	Cold conditions (natural origins)
	28	Other specified external cause
	29	Unspecified external cause
	30	Struck by or collision with person
	31	Struck by or collision with object

Guide for use: This data domain is for use in injury surveillance purposes only, when it is not possible to use a complete ICD-10-AM code (eg. Non-admitted patients in emergency departments). Select the item which best characterises the circumstances of the injury, on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate select the one that comes first in the code list. The External cause – non-admitted patient group must always be accompanied by an External cause – human intent code (see data element External cause – human intent – injury surveillance).

Verification rules:

Collection methods:

Related data: supersedes previous data element External cause – major external cause, version 3

is used in conjunction with Place of occurrence of external cause of injury – non-admitted patient, version 3

is used in conjunction with Narrative description of injury event, version 1

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

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

is used in conjunction with Activity when injured, version 1

is used in conjunction with External cause – human intent, version 4

Administrative attributes

Source document:

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

National minimum data sets:

Comments: This item has been developed to cater for the information requirements of the wide range of settings undertaking injury surveillance who do not have the capability of recording the complete ICD-10-AM external cause codes. This code list has been derived from the ICD-10-AM external cause classification. Further information on the national injury surveillance program can be obtained from the National Injury Surveillance Unit, Flinders University, Adelaide.

Narrative description of injury event

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000099 *Version number:* 1

Data element type: DATA ELEMENT

Definition: A text description of the injury event.

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

Relational and representational attributes

Datatype: Alphanumeric *Representational form:* TEXT

Field size: *Min.* 0 *Max.* 100 *Representational layout:* Text

Data domain: Text up to 100 characters in length

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

Verification rules:

Collection methods:

Related data: is qualified by External cause – human intent, version 3
is qualified by Activity when injured, version 1

Administrative attributes

Source document:

Source organisation: National Injury Surveillance Unit

National minimum data sets:

Injury surveillance from 1/07/89 to

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

Neonatal death

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000101 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

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

Context: Perinatal

Relational and representational attributes

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 Development Committee

National minimum data sets:

Perinatal 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).

Stillbirth (foetal death)

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000160 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

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

Context: Perinatal

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 Development Committee

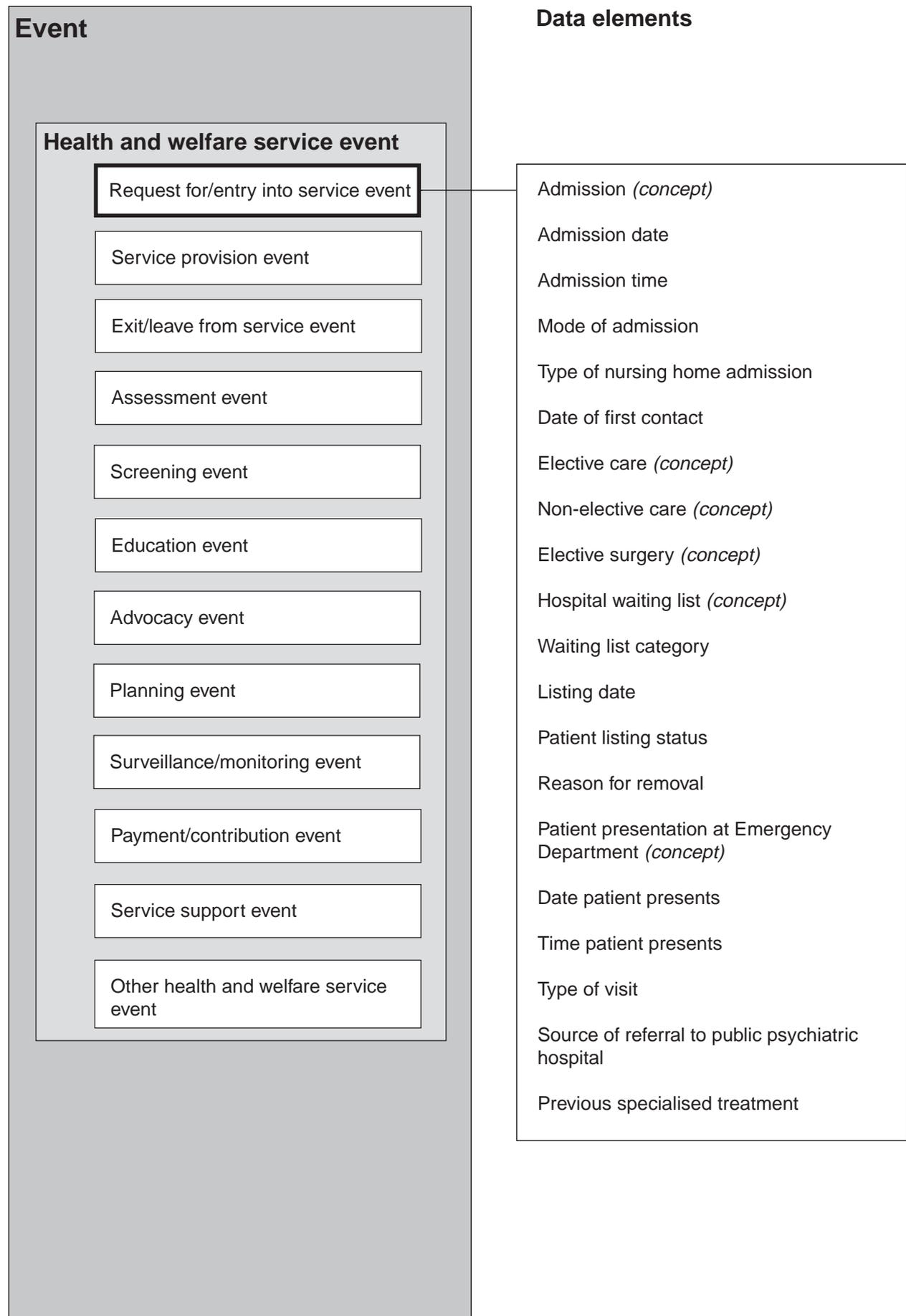
National minimum data sets:

Perinatal 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



Admission

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000007 *Version number:* 2

Data element type: DATA ELEMENT CONCEPT

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

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

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

Context: Institutional health care

Relational and representational attributes

Datatype: *Representational form:*

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

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data: supersedes previous data element Admission, version 1
relates to the data element Type of episode of care, version 3
relates to the data element concept Admitted patient, version 2
relates to the data element Admission date, version 4
relates to the data element Admission time, version 2
relates to the data element concept Separation, version 2

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

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

Admission date

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000008 *Version number:* 4

Data element type: DATA ELEMENT

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* DATE

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

Data domain:

Guide for use:

Verification rules: Right justified and zero filled.
Admission date <= separation date.
Admission date >= date of birth

Collection methods:

Related data: is used in the calculation of Length of stay, version 1
supersedes previous data element Admission date, version 3
is used in the derivation of Diagnosis related group, version 1
is used in the calculation of Emergency Department waiting time to admission, version 1
relates to the data element Type of visit, version 1
relates to the data element Departure status, version 1
is used in conjunction with Type of episode of care, version 3
relates to the data element concept Admitted patient, version 2
is used in the calculation of Waiting time at admission, version 1
relates to the data element concept Admission, version 2
relates to the data element Admission time, version 2

Administrative attributes

Source document:

Source organisation: National Health Data Committee

Admission date (*continued*)

National minimum data sets:

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

Comments:

Admission time

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000358 *Version number:* 2

Data element type: DATA ELEMENT

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

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

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

Guide for use:

Verification rules:

Collection methods:

Related data: relates to the data element Type of visit, version 1
supersedes previous data element Admission time, version 1
relates to the data element Departure status, version 1
relates to the data element concept Admitted patient, version 2
relates to the data element concept Admission, version 2
is used in conjunction with Admission date, version 4

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Comments:

Mode of admission

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000385 *Version number:* 4

Data element type: DATA ELEMENT

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

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

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

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

Verification rules:

Collection methods:

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

supplements the data element Mode of separation, version 2

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

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

Comments:

Type of nursing home admission

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000172 *Version number:* 1

Data element type: DATA ELEMENT

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

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

Guide for use:

Verification rules:

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

Related data:

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

Comments: This data element will be reviewed during 1999.

Date of first contact

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000039 *Version number:* 2

Data element type: DATA ELEMENT

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

The definition includes:

- visits made to a person in institutional settings such as liaison visits or discharge planning visits, made in a hospital or nursing home with the intent of planning for the future delivery of service at home;
- telephone contacts when these are in lieu of a first home or hospital visit for the purpose of preliminary assessment for care at home;
- visits made to the person's home prior to admission for the purpose of assessing the suitability of the home environment for the person's care.

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

The definition excludes:

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* DATE

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

Data domain: Valid date

Guide for use:

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

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

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

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

Date of first contact (*continued*)

Administrative attributes

Source document:

Source organisation: Australian Council of Community Nursing Services

National minimum data sets:

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

Elective care

Admin. status: CURRENT 1/07/95

Identifying and definitional attributes

Knowledgebase ID: 000348 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

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

Context: Institutional health care

Relational and representational attributes

Datatype: *Representational form:*

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

Data domain:

Guide for use:

Verification rules:

Collection methods:

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

Administrative attributes

Source document:

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

National minimum data sets:

Elective surgery waiting times from 1/07/94 to

Comments:

Non-elective care

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000105 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

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

Context: Institutional health care

Relational and representational attributes

Datatype: *Representational form:*

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

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data:

Administrative attributes

Source document:

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

National minimum data sets:

Elective surgery waiting times from 1/07/94 to

Comments:

Elective surgery

Admin. status: CURRENT 1/07/95

Identifying and definitional attributes

Knowledgebase ID: 000046 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

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

Context: Institutional health care

Relational and representational attributes

Datatype: *Representational form:*

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

Data domain:

Guide for use:

Verification rules:

Collection methods:

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

Administrative attributes

Source document:

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

National minimum data sets:

Elective surgery waiting times from 1/07/94 to

Comments:

Hospital waiting list

Admin. status: CURRENT 1/07/95

Identifying and definitional attributes

Knowledgebase ID: 000067 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

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

Context: Institutional health care

Relational and representational attributes

Datatype: *Representational form:*

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

Data domain:

Guide for use:

Verification rules:

Collection methods:

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

relates to the data element Waiting list category, version 3

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

Elective surgery waiting times from 1/07/94 to

Comments:

Waiting list category

Admin. status: CURRENT 1/01/95

Identifying and definitional attributes

Knowledgebase ID: 000176 *Version number:* 3

Data element type: DATA ELEMENT

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

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain: 1 Elective surgery
2 Other

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

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

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

- organ or tissue transplant procedures
- procedures associated with obstetrics (eg. elective caesarean section, cervical suture)
- cosmetic surgery, ie. when the procedure will not attract a Medicare rebate
- biopsy of:
 - kidney (needle only)
 - lung (needle only)
 - liver and gall bladder (needle only)
- bronchoscopy (including fibre-optic bronchoscopy)
- peritoneal renal dialysis; haemodialysis
- colonoscopy
- endoscopic retrograde cholangio-pancreatography (ERCP)
- endoscopy of:
 - biliary tract
 - oesophagus

Waiting list category (*continued*)

Guide for use (cont'd):

- small intestine
- stomach
- endovascular interventional procedures
- gastroscopy
- miscellaneous cardiac procedures
- oesophagoscopy
- panendoscopy (except when involving the bladder)
- proctosigmoidoscopy
- sigmoidoscopy
- anoscopy
- urethroscopy and associated procedures
- dental procedures not attracting a Medicare rebate
- other diagnostic and non-surgical procedures.

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

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

Verification rules:

Collection methods:

Related data:

- relates to the data element concept Elective care, version 1
- supersedes previous data element Waiting list category – ICD-9-CM code, version 2
- is used in conjunction with Patient listing status, version 3
- is supplemented by the data element Indicator procedure, version 3

Administrative attributes

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

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

National minimum data sets:

Elective surgery waiting times from 1/07/94 to

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

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

Waiting list category (*continued*)

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

ICD-10-AM CODES FOR THE EXCLUDED PROCEDURES:

Organ or tissue transplant procedures

90172-00 90204-00 90204-01 13706-08 90172-01 90324-00
 90205-00 36503-00 13706-00 13706-06 13706-07 36503-01
 13700-00 30375-21 90317-00 90324-00 14203-01

Procedures associated with obstetrics

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

Cosmetic surgery

to be advised by NCCH

Biopsy (needle) of:

- kidney (needle only) 36561-00
 - lung (needle only) 38412-00
 - liver and gall bladder (needle only) 30409-00 30412-00 90319-01 30094-04

Bronchoscopy (including fibre-optic bronchoscopy)

41889-00 41892-00 41904-00 41764-02 41895-00 41764-04
 41892-01 41901-00 41846-00 41898-00 41898-01 41889-01
 41849-00 41764-03 41855-00

Peritoneal renal dialysis; haemodialysis

13100-06 13100-07 13100-08 13100-00

Endoscopy of:

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

Waiting list category (*continued*)

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

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

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

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

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

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

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

Dental procedures not attracting a Medicare rebate
to be advised by NCCH

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

Listing date

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000082 *Version number:* 2

Data element type: DATA ELEMENT

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* DATE

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

Data domain: Valid dates

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

Verification rules:

Collection methods:

Related data: Supersedes previous data element Listing date, version 1
is used in conjunction with Patient listing status, version 3
is used in conjunction with Scheduled admission date, version 2
is used in the calculation of Waiting time at a census date, version 1
is used in the calculation of Waiting time at admission, version 1

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Elective surgery waiting times from 1/07/94 to

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

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

Patient listing status

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000120 *Version number:* 3

Data element type: DATA ELEMENT

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

Context:

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:
1 Ready for care
2 Not ready for care

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

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

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

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

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

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

Verification rules:

Collection methods:

Related data: relates to the data element concept Hospital waiting list, version 1
supersedes previous data element Patient listing status, version 2

Patient listing status (*continued*)

Related data (cont'd): is used in conjunction with Waiting list category, version 3
is a qualifier of Category reassignment date, version 2

Administrative attributes

Source document:

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

National minimum data sets:

Elective surgery waiting times from 1/07/94 to

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

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

Reason for removal

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000142 *Version number:* 2

Data element type: DATA ELEMENT

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

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

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

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

Verification rules:

Collection methods:

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

Administrative attributes

Source document:

Reason for removal (*continued*)

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

National minimum data sets:

Elective surgery waiting times from 1/07/94 to

Comments:

Patient presentation at Emergency Department

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000349 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

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

- registered clerically; or

- triaged; or

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

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

Context: Institutional health care

Relational and representational attributes

Datatype: *Representational form:*

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

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data:

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

Emergency Department waiting times from 1/07/99 to

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

Date patient presents

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000350 *Version number:* 1

Data element type: DATA ELEMENT

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* DATE

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

Data domain: Valid dates

Guide for use:

Verification rules:

Collection methods:

Related data:

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

Administrative attributes

Source document:

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

National minimum data sets:

Emergency Department waiting times from 1/07/99 to

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

Time patient presents

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000351 *Version number:* 1

Data element type: DATA ELEMENT

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

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

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

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

Verification rules:

Collection methods:

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

Administrative attributes

Source document:

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

National minimum data sets:

Emergency Department waiting times from 1/07/99 to

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

Type of visit

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000352 *Version number:* 1

Data element type: DATA ELEMENT

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

1	Emergency presentation: Attendance for an actual or suspected condition which is sufficiently serious as to require acute unscheduled care.
2	Return visit – planned: Presentation is planned and is a result of a previous Emergency Department presentation or return visit.
3	Pre-arranged admission: A patient who presents at the Emergency Department for either clerical, nursing or medical processes to be undertaken, and admission has been pre-arranged by the referring medical officer and a bed allocated.
4	Patient in transit: The Emergency Department is responsible for care and treatment of a patient awaiting transport to another institution
5	Dead on arrival: A patient who is dead on arrival at presentation to the Emergency Department

Guide for use:

Verification rules:

Collection methods:

Related data:

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

Type of visit (*continued*)

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

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

relates to the data element Admission time, version 1

Administrative attributes

Source document:

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

National minimum data sets:

Emergency Department waiting times from 1/07/99 to

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

Source of referral to public psychiatric hospital

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000150 *Version number:* 3

Data element type: DATA ELEMENT

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

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

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

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

Guide for use:

Verification rules:

Collection methods:

Related data: supersedes previous data element Source of referral, version 1
supplements the data element Mode of separation, version 2

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Comments: This data element is under review during 1999.

Previous specialised treatment

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000139 *Version number:* 3

Data element type: DATA ELEMENT

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

Context:

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

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

Data domain:

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

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

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

Verification rules:

Collection methods:

Related data: supersedes previous data element First admission for psychiatric treatment, version 2

relates to the data element concept Service contact, version 1

Administrative attributes

Source document:

Previous specialised treatment (*continued*)

Source organisation: National Health Data Committee/National Mental Health Information Strategy Committee

National minimum data sets:

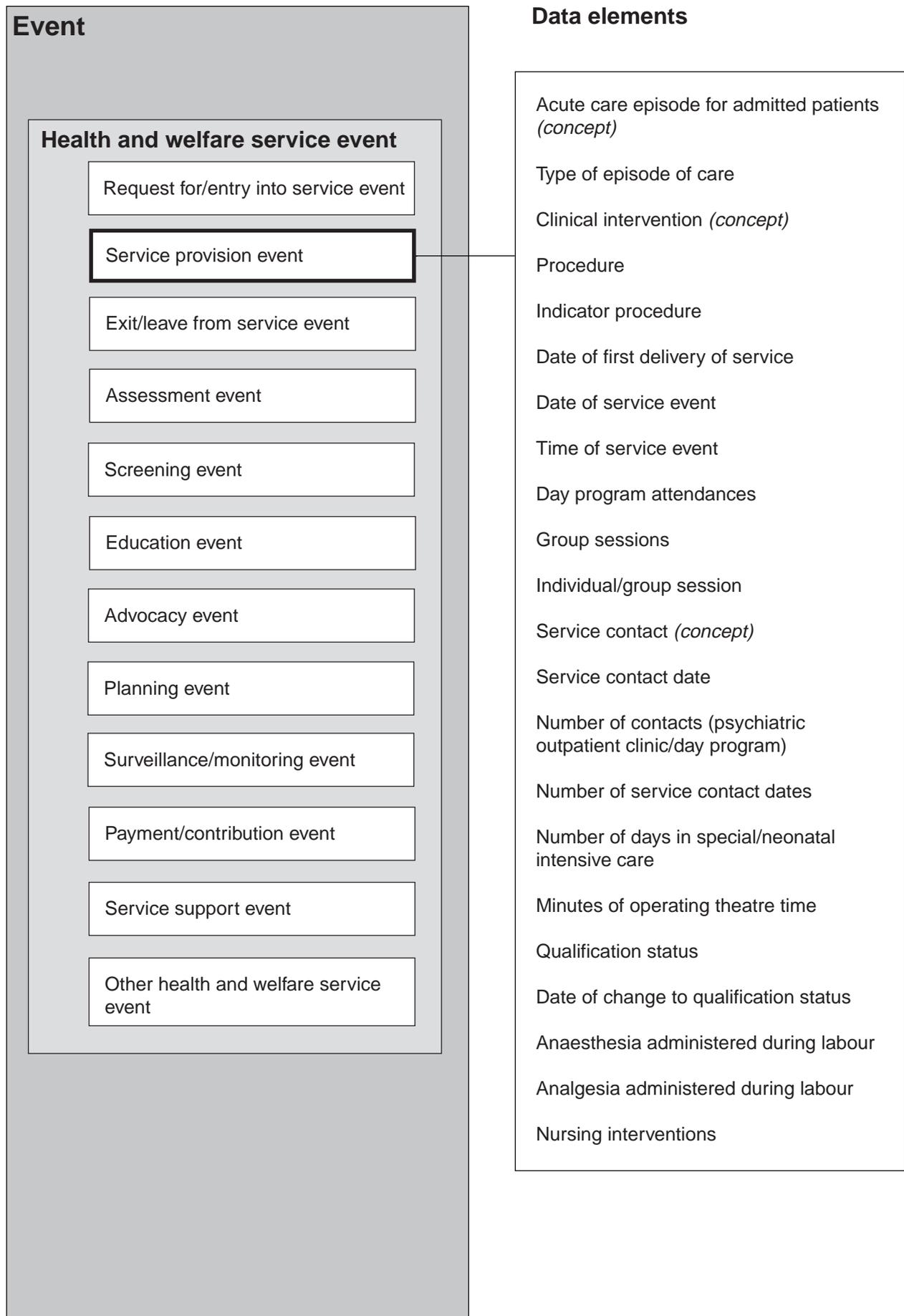
Institutional mental health care from 1/07/99 to

Palliative care from 1/07/2000 to

Comments: This data item was originally developed in the context of mental health institutional care data development (originally 'Problem status' and later 'First admission for psychiatric treatment'). More recent data development work, particularly in the area of palliative care, led to the need for this data item to be re-worded in more generic terms for inclusion in other data sets.

For palliative care, the value of this data element is in its use in enabling approximate identification of the number of new palliative care patients receiving specialised treatment. The use of this data element in this way would be improved by the reporting of this data by community-based services.

National Health Information Model entities



Acute care episode for admitted patients

Admin. status: CURRENT 1/07/95

Identifying and definitional attributes

Knowledgebase ID: 000004 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

Definition: An episode of acute care for an admitted patient is one in which the principal clinical intent is to do one or more of the following:

- manage labour (obstetric);
- cure illness or provide definitive treatment of injury;
- perform surgery;
- relieve symptoms of illness or injury (excluding palliative care);
- reduce severity of illness or injury;
- protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal functions;
- perform diagnostic or therapeutic procedures.

Context: Institutional health care

Relational and representational attributes

Datatype: *Representational form:*

Field size: *Min.* *Max.* *Representational layout:*

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data: relates to the data element Type of episode of care, version 2

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Comments:

Type of episode of care

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000168 *Version number:* 3

Data element type: DATA ELEMENT

Definition: An episode of care is a phase of treatment. It is described by one of the following types of care:

- An episode of acute care for an admitted patient is one in which the principal clinical intent is one or more of the following:
 - to manage labour (obstetric);
 - to cure illness or provide definitive treatment of injury;
 - to perform surgery;
 - to relieve symptoms of illness or injury (excluding palliative care);
 - to reduce severity of an illness or injury;
 - to protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function; and/or
 - to perform diagnostic or therapeutic procedures.

An episode of rehabilitation care occurs when a person with a disability is participating in a multidisciplinary program aimed at an improvement in functional capacity, retraining in lost skills and/or change in psychosocial adaptation.

An episode of palliative care occurs when a person's condition has progressed beyond the stage where curative treatment is effective and attainable or, where the person chooses not to pursue curative treatment. Palliation provides relief of suffering and enhancement of quality of life for such a person. Interventions such as radiotherapy, chemotherapy, and surgery are considered part of the palliative episode if they are undertaken specifically to provide symptomatic relief.

An episode of non-acute care includes care provided to persons who:

- are Nursing Home Type Patients (NHTPs), i.e. when a patient has been in hospital (public and private) for a continuous period exceeding 35 days and does not have a current acute care certificate issued under s.3B of the Health Insurance Act 1973 (Cwlth) or, alternatively, an order made under s.3A of that Act which determines that the patient is in need of acute care for a specified period;
- are not NHTPs or would normally not require hospital treatment but where there are factors in the home environment (physical, social, psychological) which make it inappropriate for the person to be discharged in the short term. This includes patients who are not eligible under current legislation to become NHTPs (compensable and ineligible patients) and have been in one or more hospitals for a continuous period of more than 35 days with a maximum break of seven days, who would otherwise be deemed to be NHTPs;

Type of episode of care (*continued*)

- Definition (cont'd):**
- are not NHTPs but are in receipt of respite care where the sole reason for admitting the person to hospital is that the care that is usually provided in another environment, e.g. at home, in a nursing home, by a relative or with a guardian, is unavailable in the short term;
 - are treated in psychiatric units who have a stable but severe level of functional impairment and inability to function independently without extensive care and support and for whom the principal function is provision of care over an indefinite period.
- A newborn episode of care is initiated when the patient is nine days old or less at the time of admission and continues until the care type changes or the patient is separated:
- those newborns who turn 10 days of age and require clinical care remain as newborn until separated;
 - those newborns who turn 10 days of age, not requiring clinical care are separated and become boarders;
 - newborns not admitted at birth (eg transferred from another hospital) aged less than 10 days will be admitted as a newborn;
 - babies not previously admitted (eg transferred from another hospital) aged greater than 9 days are either boarders or admitted with an acute care type;
 - within a newborn episode, until the baby turns 10 days of age, each day is deemed to be either an qualified or unqualified day. A newborn is qualified when it meets at least one of the following:
 - is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient;
 - is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the purpose of the provision of special care;
 - is admitted to, or remains in hospital without its mother.
 - If a newborn episode continues after the baby turns 10 days of age (requires clinical care) each day is counted as an acute day.
- NB. newborn qualified days are equivalent to acute days and for practical purposes may be denoted as such.
- An other episode of care is one where the principal clinical intent does not meet the criteria for any of the above.

Context: Institutional health care: the identification of different episodes of care is required in order to appropriately classify and count the care a person received whilst in hospital. The type of care received will determine the appropriate casemix classification that shall be employed to classify the episode.

Relational and representational attributes

Datatype:	Numeric	Representational form:	CODE
Field size:	<i>Min.</i> 3 <i>Max.</i> 3	Representational layout:	N.N

Type of episode of care (*continued*)

<i>Data domain:</i>	1.0	Acute care
	2.1	Rehabilitation care delivered in a designated unit
	2.2	Rehabilitation care according to a designated program
	2.3	Rehabilitation care principal clinical intent
	3.1	Palliative care delivered in a designated unit
	3.2	Palliative care according to a designated program
	3.3	Palliative care principal clinical intent
	4.0	Non-acute care
	5.0	Newborn
	6.0	Other care

Guide for use: An episode of care refers to the phase of treatment rather than to each individual patient day. There may be more than one episode of care within the one overnight stay period.

An episode of care begins on the date the person meets criteria defined above for a particular type of care; this may be the same as the date the person was admitted to hospital or a date during the hospital stay. An episode of care ends when the principal clinical intent of the care changes or when the patient is formally separated from the hospital.

A rehabilitation episode includes care provided:

- in a designated rehabilitation unit;
- in a designated rehabilitation program, or in a psychiatric rehabilitation program as designated by the state health authority for Medicare patients in a recognised hospital, for private patients in a public or private hospital as approved by a registered health benefits organisation; or
- under the principal clinical management of a rehabilitation physician, or in the opinion of the treating doctor the principal clinical intent of care is rehabilitation.

A palliative episode of care includes care provided:

- in a palliative care unit;
- in a designated palliative care program; or
- under the principal clinical management of a palliative care physician or in the opinion of the treating doctor the principal clinical intent of care is palliation.

Coding for rehabilitation/palliative care should be carried out in strict numerical sequence and only the first appropriate category should be coded; i.e. when a patient under the clinical management of a rehabilitation/palliative care physician is receiving care in a designated program, the episode should be coded to the option that is highest in the hierarchy (designated program).

Persons with mental illness may fall into any one of the care types (except newborn); classification depends on the principal clinical intent of the care received.

Type of episode of care (*continued*)

Guide for use (cont'd): The Nursing Home Type Patient criteria apply to all admitted patients regardless of the type of episode of care the patient is receiving. Once a patient meets these criteria they should be classified as a Nursing Home Type Patient.

Verification rules:

Collection methods:

Related data:

- supersedes previous data element Type of episode of care, version 2
- is used in conjunction with Date of change to qualification status, version 1
- is used in conjunction with Qualification status, version 1
- is used in conjunction with Number of acute (qualified)/unqualified days for newborns, version 1

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care	from 1/07/89 to
Institutional mental health care	from 1/07/97 to
Palliative care	from 1/07/2000 to

Comments: Newborn episode: It should be noted that unqualified newborn days (and separations consisting entirely of unqualified newborn days are not to be counted under the Australian Health Care Agreements and that they are ineligible for health insurance benefit purposes.

During 1996 an National Health Data Committee Working Party considered the differing admission practices between States/Territories relating to qualified/unqualified babies. The major finding was that while, all States/Territories based their qualified/unqualified distinction on NHDD Version 5.0 definitions and the Commonwealth Circular HBF456, there was a significant difference in the implementation of P21 Type of episodes of care in regard to unqualified newborns. It is recommended that users of data contact individual State/Territory Health Authorities for advice on implementation of newborn episodes of care in that jurisdiction. The changes to this data element and the development of a method of capture of qualified/unqualified days will enable the implementation and reporting of a single episode of newborn care.

At its meeting in November 1996, the National Health Information Management Group requested that a single episode approach for newborn hospital stays be incorporated into the NHDD. This would facilitate differentiation between healthy and sick babies on the basis of clinical criteria as opposed to whether they were cared for in neonatal intensive care.

Clinical intervention

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000399 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

Definition: An intervention carried out to improve, maintain or assess the health of a person, in a clinical situation.

Clinical interventions include invasive and non-invasive procedures, and cognitive interventions.

Invasive:

(a) Therapeutic interventions where there is a disruption of the epithelial lining generally, but not exclusively, with an implied closure of an incision (e.g. operations such as cholecystectomy or administration of a chemotherapeutic drug through a vascular access device);

(b) Diagnostic interventions where an incision is required and/or a body cavity is entered (e.g. laparoscopy with/without biopsy, bone marrow aspiration).

Non-invasive:

Therapeutic or diagnostic interventions undertaken without disruption of an epithelial lining (e.g. lithotripsy, hyperbaric oxygenation; allied health interventions such as hydrotherapy; diagnostic interventions not requiring an incision or entry into a body part such as pelvic ultrasound, diagnostic imaging).

Cognitive:

An intervention which requires cognitive skills such as evaluating, advising, planning (e.g. dietary education, physiotherapy assessment, crisis intervention, bereavement counselling).

Context: Health services: Information about the surgical and non-surgical interventions provides the basis for analysis of health service usage, especially in relation to specialised resources, for example theatres and equipment or human resources.

Relational and representational attributes

Datatype: *Representational form:*

Field size: *Min.* *Max.* *Representational layout:*

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data:

Clinical intervention (*continued*)

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Comments: Classification and coding systems for procedures include the International Statistical Classification of Diseases and Related Health Problems – Tenth Revision – Australian Modification, 1998 (ICD-10-AM) and the International Classification of Primary Care (1987).

Procedure

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000137 *Version number:* 5

Data element type: DATA ELEMENT

Definition: A clinical intervention that:

- is surgical in nature; and/or
- carries a procedural risk; and/or
- carries an anaesthetic risk; and/or
- requires specialised training; and/or
- requires special facilities or equipment only available in an acute care setting.

Context: Institutional health care: this item gives an indication of the extent to which specialised resources, for example, human resources, theatres and equipment, are used. It also provides an estimate of the numbers of surgical operations performed and the extent to which particular procedures are used to resolve medical problems. It is used for classification of episodes of acute care for admitted patients into Australian Refined Diagnosis Related Groups.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 7 *Max.* 7 *Representational layout:* NNNNN-NN

Data domain:

Guide for use: Admitted patients: record all procedures undertaken during an episode of care in accordance with the ICD-10-AM Australian Coding Standards.

The order of codes should be determined using the following hierarchy:

- procedure performed for treatment of the principal diagnosis
- procedure performed for the treatment of an additional diagnosis
- diagnostic/exploratory procedure related to the principal diagnosis; or
- diagnostic/exploratory procedure related to an additional diagnosis for the episode of care.

The first edition of ICD-10-AM, the Australian modification of ICD-10, was published by the National Centre for Classification in Health and implemented from July 1998. The second edition will be published for use from July 2000.

New South Wales, Victoria, the Australian Capital Territory and the Northern Territory implemented ICD-10-AM from 1 July 1998. Other States will implement this classification from 1 July 1999.

Verification rules: As a minimum requirement procedure codes must be valid codes from ICD-10-AM procedure codes and validated against the nationally agreed age and sex edits. More extensive edit checking of codes may be utilised within individual hospitals and State and Territory information systems.

Procedure (*continued*)

Collection methods: Record and code all procedures undertaken during the episode of care in accordance with the ICD-10-AM Australian Coding Standards. An unlimited number of diagnosis and procedure codes should be able to be collected in hospital morbidity systems. Where this is not possible, a minimum of 20 codes should be able to be collected. Procedures are derived from and must be substantiated by clinical documentation.

Related data: supersedes previous data element Principal procedure – ICD-9-CM code, version 3

supersedes previous data element Additional procedures– ICD-9-CM code, version 3

is used in conjunction with Indicator procedure, version 3

is qualified by Principal diagnosis, version 3

is qualified by Additional diagnosis, version 4

supersedes previous data element Principal procedure – ICD-10-AM code, version 4

supersedes previous data element Additional procedures – ICD-10-AM code, version 4

Administrative attributes

Source document: International Statistical Classification of Diseases and Related Health Problems – Tenth Revision – Australian Modification (1998); National Centre for Classification in Health, Sydney.

Source organisation: National Centre for Classification in Health, National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/99 to

Comments: The National Centre for Classification in Health advises the National Health Data Committee of relevant changes to the ICD-10-AM.

Indicator procedure

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000073 *Version number:* 3

Data element type: DATA ELEMENT

Definition: An indicator procedure is a procedure which is of high volume, and is often associated with long waiting periods.

Context: Waiting list statistics for indicator procedures give a specific indication of performance in particular areas of elective care provision.

It is not always possible to code all elective surgery procedures at the time of addition to the waiting list. Reasons for this include that the surgeon may be uncertain of the exact procedure to be performed, and that the large number of procedures possible and lack of consistent nomenclature would make coding errors likely. Furthermore, the increase in workload for clerical staff may not be acceptable. However, a relatively small number of procedures account for the bulk of the elective surgery workload. Therefore, a list of common procedures with a tendency to long waiting times is useful.

Waiting time statistics by procedure are useful to patients and referring doctors. In addition, waiting time data by procedure assists in planning and resource allocation, audit and performance monitoring.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 2 *Max.* 2 *Representational layout:* NN

Data domain:

01	Cataract extraction
02	Cholecystectomy
03	Coronary artery bypass graft
04	Cystoscopy
05	Haemorrhoidectomy
06	Hysterectomy
07	Inguinal herniorrhaphy
08	Myringoplasty
09	Myringotomy
10	Prostatectomy
11	Septoplasty
12	Tonsillectomy
13	Total hip replacement
14	Total knee replacement
15	Varicose veins stripping and ligation
16	Not applicable

Indicator procedure (*continued*)

Guide for use: These procedure terms are defined by the ICD-10-AM (1998) codes which are listed in comments below. Where a patient is awaiting more than one indicator procedure, all codes should be listed. This is because the intention is to count procedures rather than patients in this instance.

These are planned procedures for the waiting list, not what is actually performed during hospitalisation.

New South Wales, Victoria, Australian Capital Territory and Northern Territory implemented ICD-10-AM from 1 July 1998, other States will be implementing ICD-10-AM from 1 July 1999.

Verification rules: Zero filled, right justified.

Collection methods:

Related data: supersedes previous data element Indicator procedure – ICD-9-CM code, version 2

supplements the data element Waiting list category, version 3

is used in conjunction with Procedure, version 5

Administrative attributes

Source document: International Statistical Classification of Diseases and Related Health Problems – Tenth Revision – Australian Modification (1998) National Centre for Classification in Health, Sydney.

Source organisation: National Health Data Committee

National minimum data sets:

Elective surgery waiting times from 1/07/94 to

Comments: The list of indicator procedures may be reviewed from time to time. Some health authorities already code a larger number of waiting list procedures.

ICD-10-AM codes.

cataract extraction:

42698-00 [195], 42702-00 [195], 42702-01 [195],
 42698-01 [196], 42702-02 [196], 42702-03 [196],
 42698-02 [197], 42702-04 [197], 42702-05 [197],
 42698-03 [198], 42702-06 [198], 42702-07 [198],
 42698-04 [199], 42702-08 [199], 42702-09 [199],
 42731-01 [200], 42698-05 [200], 42702-10 [200],
 42722-00 [201], 42734-00 [201], 42788-00 [201],
 42719-00 [201], 42731-00 [201], 42719-02 [201],
 42791-02 [201], 42702-11 [200], 42716-00 [202]

cholecystectomy:

30443-00 [965], 30454-01 [965], 30455-00 [965],
 30445-00 [965], 30446-00 [965], 30448-00 [965],
 30449-00 [965]

Indicator procedure (*continued*)

Comments (cont'd): coronary artery bypass graft:
38497-00 [672], 38497-01 [672], 39497-02 [672],
38497-03 [672], 38497-04 [673], 38497-05 [673],
38497-06 [673], 39497-07 [673], 38500-00 [674],
38503-00 [674], 38500-01 [675], 38503-01 [675],
38500-02 [676], 38503-02 [676], 38500-03 [677],
38503-03 [677], 38500-04 [678], 38503-04 [678],
90201-00 [679], 90201-01 [679], 90201-02 [679],
90201-03 [679]

cystoscopy:
36812-00 [1088], 36812-01 [1088], 36836-00 [1097]

haemorrhoidectomy:
32138-00 [949], 32132-00 [949], 32135-00 [949], 32135-01 [949]

hysterectomy:
35653-00 [1268], 35653-01 [1268],
35653-02 [1268], 35653-03 [1268],
35661-00 [1268], 35670-00 [1268],
35667-00 [1268], 35664-00 [1268],
35657-00 [1269], 35750-00 [1269],
35756-00 [1269], 35673-00 [1269],
35673-01 [1269], 35753-00 [1269],
35753-01 [1269], 35756-01 [1269],
35756-02 [1269], 35667-01 [1269],
35664-01 [1269], 90450-00 [1238],
90450-01 [1269], 90450-02 [1238]

inguinal herniorrhaphy:
30614-03 [990], 30615-00 [997], 30609-03 [990], 30614-02 [990], 30609-02 [990]

myringoplasty:
41527-00 [313], 41530-00 [313], 41533-01 [313], 41542-00 [315]

myringotomy:
41626-00 [309], 41626-01 [309], 41632-00 [309], 41632-01 [309]

prostatectomy:
37203-00 [1165], 37203-01 [1165],
37203-02 [1165], 37207-00 [1166],
37207-01 [1166], 37200-00 [1166],
37200-01 [1166], 37200-02 [1166],
37200-06 [1166], 37200-03 [1167],
37200-04 [1167], 37209-00 [1167],
37200-05 [1167], 90407-00 [1168],
36839-03 [1162], 36869-01 [1162]

Indicator procedure (*continued*)

Comments (cont'd): septoplasty:
41671-02 [379], 41671-03 [379], 41671-00 [378]

tonsillectomy:
41789-00 [412], 41789-01 [[412]

total hip replacement:
49318-00 [1489], 49319-00 [1489],
49324-00 [1492], 49327-00 [1492],
49330-00 [1492], 49333-00 [1492],
49345-00 [1492], 49346-00 [1492]

total knee replacement:
49518-00 [1518], 49519-00 [1518],
49521-00 [1519], 49521-01 [1519],
49521-02 [1519], 49521-03 [1519],
49524-00 [1519], 49524-01 [1519],
49527-00 [1524], 49530-00 [1523],
49530-01 [1523], 49533-00 [1523],
49554-00 [1523], 49534-00 [1519],
49517-00 [1518]

varicose veins:
32508-00 [727], 32508-01 [727], 32511-00 [727],
32504-01 [728], 32505-00 [728], 32514-00 [737]

Date of first delivery of service

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000038 *Version number:* 2

Data element type: DATA ELEMENT

Definition: The date of first delivery of service to a person in a non-institutional setting.

The definition excludes:

- visits made to persons in institutional settings such as liaison visits or discharge planning visits, made in a hospital or nursing home, with the intent of planning for the future delivery of community-based services;

- first visits where there is no contact with the person, such as a first visit where no-one is at home.

- telephone, letter or other such contacts made with the person prior to the first home visit.

In situations where the first delivery of service determines that no future visit needs to be made, the Date of first Delivery of service and the Date of last delivery of service will be the same.

Context: The Date of first delivery of service is used for the analysis of time periods within a care episode and to locate that episode in time. The date relates to the first delivery of formal services within the community setting.

Relational and representational attributes

Datatype: Numeric *Representational form:* DATE

Field size: *Min.* 8 *Max.* 8 *Representational layout:* DDMMYYYY

Data domain: Valid dates

Guide for use:

Verification rules: This date may occur on the same day or prior to the Date of last delivery of service, but must never occur after that date within the current episode of care. The date may be the same as the Date of first contact.

Collection methods: As long as contact is made with the person in a non-institutional setting, the Date of first delivery of service must be recorded. Normally this will be the first home or clinic visit and is the date most often referred to in a service agency as the admission. This date applies whether a person is being admitted for the first time, or is being re-admitted for care.

Related data: supersedes previous data element Date of first community nursing visit, version 1 relates to the data element Date of first delivery of service, version 2

Administrative attributes

Source document:

Date of first delivery of service (*continued*)

Source organisation: Australian Council of Community Nursing Services

National minimum data sets:

Comments: This date marks the most standard event, which occurs at the beginning of an episode of care in community setting. It should not be confused with the Date of first contact with a community nursing service; although they could be the same, the dates for both items must be recorded. Agencies providing hospital in the Home services should develop their own method of distinguishing between the period the person remains a formal patient of the hospital, with funding to receive services at home, and the discharge of the person into the care of the community service.

Date of service event

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000356 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The day on which the delivery of a service commences. The service is defined as commencing when a medical officer (or, if no medical officer is on duty in the Emergency Department, a treating nurse) first takes responsibility for the patient's care. The commencement of assessment of the patient by the medical officer is included as taking responsibility for care.

Context: Institutional health care: Required to identify the commencement of the service and calculation of waiting times.

Relational and representational attributes

Datatype: Numeric *Representational form:* DATE

Field size: *Min.* 8 *Max.* 8 *Representational layout:* DDMMYYYY

Data domain: Valid dates

Guide for use:

Verification rules:

Collection methods:

Related data: relates to the data element Emergency Department waiting time to service delivery, version 1

relates to the data element concept Patient presentation at Emergency Department, version 1

relates to the data element Time of service event, version 1

Administrative attributes

Source document:

Source organisation: National Institution Based Ambulatory Model Reference Group; National Health Data Committee

National minimum data sets:

Emergency Department waiting times from 1/07/99 to

Comments: This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department Waiting Times National Minimum Data Set.

Time of service event

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000357 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The time at which the delivery of a service commences. The service is defined as commencing when a medical officer (or, if no medical officer is on duty in the Emergency Department, a treating nurse) first takes responsibility for the patient's care. The commencement of assessment of the patient by the medical officer is included as taking responsibility for care.

Context: Institutional health care

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 4 *Max.* 4 *Representational layout:* HHMM

Data domain: Expressed as hours and minutes using 24-hour clock

Guide for use:

Verification rules:

Collection methods:

Related data:

- relates to the data element Admission date, version 3
- relates to the data element Emergency Department waiting time to service delivery, version 1
- relates to the data element Emergency Department waiting time to admission, version 1
- relates to the data element concept Patient presentation at Emergency Department, version 1
- relates to the data element Date patient presents, version 1
- relates to the data element Time patient presents, version 1
- relates to the data element Type of visit, version 1
- relates to the data element Time of triage, version 1
- relates to the data element Date of service event, version 1
- relates to the data element Admission time, version 1

Administrative attributes

Source document:

Source organisation: National Institution Based Ambulatory Model Reference Group; National Health Data Committee

National minimum data sets:

Emergency Department waiting times from 1/07/99 to

Comments:

Day program attendances

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000211 *Version number:* 1

Data element type: DERIVED DATA ELEMENT

Definition: A count of the number of patient/client visits to day centres. Each individual is to be counted once for each time they attend a day centre. Where an individual is referred to another section of the hospital/centre and returns to the day centre after treatment only one visit is to be recorded.

Context: Required to measure adequately non-admitted patient services in psychiatric hospitals and alcohol and drug hospitals.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 5 *Representational layout:* NNNNN

Data domain: Number of attendances

Guide for use:

Verification rules:

Collection methods:

Related data:

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

Comments: Difficulties were envisaged in using the proposed definitions of an individual or group occasion of service for clients attending psychiatric day care centres. These individuals may receive both types of services during a visit to a centre.

This data element is derived from data elements that are not currently specified in the National Health Data Dictionary, but which are recorded in various ways by hospitals and/or outpatient departments. Examples include identifiers of individual consultations/visits, diagnostic tests, etc. Further specification/development of these data elements is expected as part of the National Institution Based Ambulatory Care Modelling (NIBAM) Project.

Group sessions

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000210 *Version number:* 1

Data element type: DERIVED DATA ELEMENT

Definition: The number of groups of patients/clients receiving services. Each group is to count once, irrespective of size or the number of staff providing services.

Context: Institutional health care: the resources required to provide services to groups of patients are different from those required to provide services to an equivalent number of individuals. Hence services to groups of non-admitted patients or outreach clients should be counted separately from services to individuals.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 6 *Representational layout:* NNNNNN

Data domain: Number of groups receiving services

Guide for use:

Verification rules:

Collection methods: At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.

Related data:

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

Institutional health care from 1/07/89 to

Comments: This data element is derived from data elements that are not currently specified in the National Health Data Dictionary, but which are recorded in various ways by hospitals and/or outpatient departments. Examples include identifiers of individual consultations/visits, diagnostic tests, etc.

Individual / group session

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000235 *Version number:* 1

Data element type: DATA ELEMENT

Definition: A group is defined as two or more patients receiving services at the same time from the same hospital staff. However, this excludes the situation where individuals all belong to the same family. In such cases the service is being provided to the family unit and as a result the session should be counted as a single occasion of service to an individual.

Context: Required to distinguish between those occasions of service on an individual patient basis and those servicing groups of patients. This distinction has resource implications.

Relational and representational attributes

Datatype: Alphanumeric *Representational form:* CODE

Field size: *Min.* 5 *Max.* 5 *Representational layout:* ANNN.N

Data domain: A12.1 Individual sessions
A12.2 Group sessions

Guide for use:

Verification rules:

Collection methods:

Related data:

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

Institutional health care from 1/07/89 to

Comments:

Service contact

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000401 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

Definition: A contact between a patient/client and an ambulatory care health unit (including outpatient and community health units) which results in a dated entry being made in the patient/client record.

Context: Identifies service delivery at the patient level for mental health services (including consultation/liaison, mobile and outreach services).

A service contact can include either face-to-face, telephone or video link service delivery modes. Service contacts would either be with a client, carer or family member or another professional or mental health worker involved in providing care and do not include contacts of an administrative nature (eg. telephone contact to schedule an appointment) except where a matter would need to be noted on a patient's record.

Service contacts may be differentiated from administrative and other types of contacts by the need to record data in the client record. However, there may be instances where notes are made in the client record that have not been prompted by a service contact with a patient/client (e.g. noting receipt of test results that require no further action). These instances would not be regarded as a service contact.

Relational and representational attributes

Datatype: *Representational form:*

Field size: *Min.* *Max.* *Representational layout:*

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data: relates to the data element Number of service contact dates, version 2
relates to the data element Service contact date, version 1

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

Comments: The proposed definition is not able to measure case complexity or level of resource usage with each service contact alone. This limitation also applies to the concept of occasions of service (in institutional health care) and hospital

Service contact (*continued*)

Comments (cont'd): separations. Some overlap with the data element Occasions of service is acknowledged by the National Health Data Committee and is subject to further work during 1999. The National Health Data Committee also acknowledges that information about group sessions or activities that do not result in a dated entry being made in each individual participant's patient/client record is not currently covered by this data element concept. The Committee will also be considering ways of capturing this information during 1999.

Service contact date

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000402 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The date of each service contact between a health service provider and patient/client.

Context: Community-based mental health care: Collection of the date of each service contact with health service providers allows a description or profile of service utilisation by a person or persons during an episode of care.

Relational and representational attributes

Datatype: Numeric *Representational form:* DATE

Field size: *Min.* 8 *Max.* 8 *Representational layout:* DDMMYYYY

Data domain: Valid date

Guide for use: Requires services to record the date of each service contact, including the same date where multiple visits are made on one day (except where the visits may be regarded as a continuation of the one service contact).

Where an individual patient/client participates in a group activity a service contact date is recorded if the person's participation in the group activity results in a dated entry being made in the patient's/client's record.

Verification rules:

Collection methods: For collection from community based (ambulatory and non-residential) agencies.

Related data: is used in the derivation of Number of service contact dates, version 2
relates to the data element concept Service contact, version 1

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

Comments: The National Health Data Committee acknowledges that information about group sessions or activities that do not result in a dated entry being made in each individual participant's patient/client record is not obtained via this data element. The Committee will be considering ways of capturing this information during 1999.

Number of contacts (psychiatric outpatient clinic/day program)

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000141 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Number of days that a patient attended a psychiatric outpatient clinic or a day program during the relevant financial year.

Context: Mental health statistics: this data element gives a measure of the level of service provided

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 3 *Representational layout:* NNN

Data domain: Count in number of days

Guide for use:

Verification rules:

Collection methods: All States and Territories where there are public psychiatric hospitals also collect date of contact, and number of contacts during the financial year can be derived from this. (Collection status for New South Wales is unknown at time of writing.)

Related data: is an alternative to Number of service contact dates, version 2

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

Community mental health care from 1/07/2000 to

Comments: In December 1998, the National Health Information Management Group decided that the new version of this data element (named Number of service contact dates) would be implemented from 1 July 2000 in the Community mental health NMDS. Until then agencies involved in the Community mental health NMDS may report either Number of contacts (psychiatric outpatient clinic/day program) or Number of service contact dates with the expectation that agencies will make their best efforts to report against the new version of this data element (Number of service contact dates) from 1 July 1999.

Number of service contact dates

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000141 *Version number:* 2

Data element type: DERIVED DATA ELEMENT

Definition: The number of dates where a service contact was recorded for the patient/client.

Context: Community-based mental health care: This data element gives a measure of the level of service provided to a patient/client.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 3 *Representational layout:* NNN

Data domain:

Guide for use: This data element is a count of service contact dates recorded on a patient or client record. Where multiple service contacts occur on the same date, the date is counted only once.

Verification rules:

Collection methods: For collection from community based (ambulatory and non-residential) agencies. Includes mental health day programs and psychiatric outpatients.

Related data: is an alternative to Number of contacts (psychiatric outpatient clinic/day program), version 1

relates to the data element concept Service contact, version 1

is derived from Service contact date, version 1

Administrative attributes

Source document:

Source organisation: National Mental Health Information Strategy Committee

National minimum data sets:

Community mental health care from 1/07/2000 to

Comments: Some overlap with the data element Occasions of service is acknowledged by the National Health Data Committee and is subject to further work during 1999. The National Health Data Committee also acknowledges that information about group sessions or activities that do not result in a dated entry being made in each individual participant's patient/client record is not obtained via this data element. The Committee will be considering ways of capturing this information during 1999.

This data element is an alternative to the data element Number of contacts (psychiatric outpatient clinic/day program). This is a transitional arrangement until 30 June 2000, whereby either data element is an acceptable standard for reporting in the Community mental health care National Minimum Data Set. From 1 July 2000, this data element (Number of service contact dates) will become the required standard for reporting this information.

Number of days in special / neonatal intensive care

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000009 *Version number:* 2

Data element type: DATA ELEMENT

Definition: Number of days spent by a neonate in a special care or neonatal intensive care nursery (in the hospital of birth).

Context: Institutional health care and perinatal statistics: an indicator of the requirements for hospital care of high-risk babies in specialised nurseries that add to costs because of extra staffing and facilities.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 3 *Representational layout:* NNN

Data domain: Number, representing the number of days spent in the special/intensive care nursery

Guide for use: The number of days is calculated from the date the baby left the special/neonatal intensive care unit minus the date the baby was admitted to the special/neonatal intensive care unit.

Verification rules:

Collection methods: This item is to be completed if baby has been treated in an intensive care unit or a special care nursery.

Special care nurseries (SCN) are staffed and equipped to provide a full range of neonatal services for the majority of complicated neonatal problems, including short-term assisted ventilation and intravenous therapy.

Neonatal intensive care nurseries (NICN) are staffed and equipped to treat critically ill newborn babies including those requiring prolonged assisted respiratory support, intravenous therapy, and alimentation and treatment of serious infections. Full supportive services are readily available throughout the hospital. These NICNs also provide consultative services to other hospitals.

Related data: supersedes previous data element Admission to special/neonatal intensive care, version 1

Administrative attributes

Source document:

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Comments:

Minutes of operating theatre time

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000094 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Total time spent by a patient in operating theatres during current episode of hospitalisation.

Context: Institutional health care

Relational and representational attributes

Datatype: Numeric *Representational form:* DATE

Field size: *Min.* 4 *Max.* 4 *Representational layout:* HHMM

Data domain:

Guide for use:

Verification rules: Right justified, zero filled.

Collection methods:

Related data:

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Comments: This item was recommended for inclusion in the National Health Data Dictionary by Hindle (1988a, 1988b) to assist with Diagnosis Related Group costing studies in Australia.

This data element has not been accepted for inclusion in the National minimum data set – institutional health care.

Qualification status

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000343 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Qualification status indicates whether the newborn day of stay is either acute (qualified) or unqualified (for all or part of a newborn episode of care).

Context: Institutional health care: To provide accurate information on care to babies to enable analysis to exclude normal babies.

Relational and representational attributes

Datatype: Alphabetic *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* A

Data domain: A acute (qualified) newborn day
U unqualified newborn day

Guide for use: A newborn is qualified if it meets at least one of the following criteria:

- is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient;
- is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the purpose of the provision of special care;
- is admitted to, or remains in hospital without its mother.

A newborn is unqualified if it does not meet any of the above criteria.

Verification rules:

Collection methods:

Related data: is used in conjunction with Admitted patient, version 1
is used in conjunction with Type of episode of care, version 2
is used in the calculation of Date of change to qualification status, version 1
is used in the calculation of Number of acute (qualified)/unqualified days for newborns, version 1

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

Comments:

Date of change to qualification status

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000342 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The date, within a newborn episode of care, on which the newborn's Qualification status changes from acute (qualified) to unqualified or vice versa.

Context:

Relational and representational attributes

Datatype: Numeric *Representational form:* DATE

Field size: *Min.* 8 *Max.* 8 *Representational layout:* DDMMYYYY

Data domain: Valid date

Guide for use: Record the date or dates on which the newborn's Qualification Status changes from acute (qualified) to unqualified or vice versa.

If more than one change of qualification status occurs on a single day, the day is counted against the final qualification status.

Verification rules: Must be greater than or equal to admission date

Collection methods:

Related data: is used in conjunction with Admitted patient, version 1

is used in conjunction with Type of episode of care, version 2

is used in conjunction with Qualification status, version 1

is used in the calculation of Number of acute (qualified)/unqualified days for newborns, version 1

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

Comments:

Anaesthesia administered during labour

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000013 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Anaesthesia administered for the operative delivery of the baby (caesarean, forceps or vacuum extraction).

Context: Perinatal statistics: anaesthetic use may influence the duration of labour, may affect the health status of the baby at birth and is an indicator of obstetric intervention.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1	None
2	Local anaesthetic to perineum
3	Pudendal
4	Epidural or caudal
5	Spinal
6	General
8	Other
9	Not stated

Guide for use: If more than one agent is used, select the largest number (excluding 8 or 9) as this is how the data are tabulated.

Verification rules:

Collection methods:

Related data: is used in conjunction with Method of birth, version 1
is used in conjunction with Apgar score, version 1

Administrative attributes

Source document:

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Comments:

Analgesia administered during labour

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000014 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Agents administered to the mother by injection or inhalation to relieve pain during labour and delivery.

Context: Perinatal statistics: analgesia use may influence the duration of labour, may affect the health status of the baby at birth and is an indicator of obstetric intervention.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1	None
2	Nitrous oxide
3	Intra-muscular narcotics
4	Epidural/caudal
5	Spinal
8	Other
9	Not stated

Guide for use: If more than one agent is used, select the largest number (excluding 8 or 9) as this is how the data will be tabulated.

Verification rules:

Collection methods:

Related data: is used in conjunction with Method of birth, version 1

Administrative attributes

Source document:

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Comments:

Nursing interventions

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000112 *Version number:* 2

Data element type: DATA ELEMENT

Definition: The nursing action/s intended to relieve or alter a person's responses to actual or potential health problems.

Context: To enable analysis of the interventions within an episode of care, in relation to the outcome of this care, especially when linked with information on the diagnosis and goals. The recording of Nursing interventions is critical information for health service monitoring and planning. It is a major descriptor of the care provided throughout an episode.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1	Coordination and collaboration of care
2	Supporting informal carers
3	General nursing care
4	Technical nursing treatment or procedure
5	Counselling and emotional support
6	Teaching/education
7	Monitoring and surveillance
8	Formal case management
9	Service needs assessment only

Guide for use: For the purposes of the CNMDSA, the interventions are not necessarily linked to each nursing problem, nor are they specific tasks, but rather, broader-level intervention categories focusing on the major areas of a person's need. These summary categories subsume a range of specific actions or tasks.

The following definitions are to assist in coding:

1. COORDINATION AND COLLABORATION OF CARE occurs when there are multiple care deliverers. The goal of coordination and collaboration is the efficient, appropriate integrated delivery of care to the person. Tasks which may be involved include: liaison, advocacy, planning, referral, information and supportive discussion and/or education. Although similar in nature to formal case management this intervention is not the one formally recognised by specific funding (see Code 8).

2. SUPPORTING INFORMATION CARERS includes activities, which the nurse undertakes to assist the carer in the delivery of the carer's role. This does not include care given directly to the person. Examples of tasks involved in supporting the carer include: counselling, teaching, informing, advocacy, coordinating, and grief or bereavement support.

Nursing interventions (*continued*)

- Guide for use (cont'd):** 3. GENERAL NURSING CARE includes a broad range of activities, which the nurse performs to directly assist the person; in many cases, this assistance will focus on activities of daily living. This assistance will help a person whose health status, level of dependency, and/or therapeutic needs are such that nursing skills are required. Examples of tasks include: assistance with washing, grooming and maintaining hygiene, dressing, pressure area care, assistance with toileting, bladder and bowel care, assistance with mobility and therapeutic exercise, attention to physical comfort and maintaining a therapeutic environment.
4. TECHNICAL NURSING TREATMENT OR PROCEDURE refers to technical tasks and procedures for which nurses receive specific training and which require nursing knowledge of expected therapeutic effect, possible side-effects, complications and appropriate actions related to each. Some examples of technical care activities are: medication administration (including injections), dressings and other procedures, venipuncture, monitoring of dialysis, and implementation of pain management technology.
5. COUNSELLING AND EMOTIONAL SUPPORT focuses on non-physical care given to the person, which aims to address the affective, psychological and/or social needs. Examples of these include: bereavement, well being, decision-making support and values-clarification.
6. TEACHING/EDUCATION refers to providing information and/or instruction about a specific body of knowledge and/or procedure, which is relevant to the person's situation. Examples of teaching areas include: disease process, technical procedure, health maintenance, health promotion and techniques for coping with a disability.
7. MONITORING AND SURVEILLANCE refers to any action by which the nurse evaluates and monitors physical, behavioural, social and emotional responses to disease, injury, and nursing or medical interventions.
8. FORMAL CASE MANAGEMENT refers to the specific formal service, which is funded to provide case management for a person. Note that coordination and collaboration of care (Code 1) is not the same as Formal Case Management.
9. SERVICE NEEDS ASSESSMENT ONLY is assessment of the person when this is the only activity carried out and no further nursing care is given; for example, assessment for ongoing care and/or inappropriate referrals. Selection of this option means that no other intervention may be nominated. Thus, if an assessment for the Domiciliary Care Benefit is the reason for a visit, but other interventions such as, counselling and support; coordination/collaboration of care are carried out, then the Assessment only is not an appropriate code.

Verification rules: Up to eight codes may be selected. If Code 9 is selected no other nursing interventions are collected. If Code 9 is selected then code 7 in Goal of care must also be selected.

Nursing interventions (*continued*)

Collection methods: Collect on continuing basis throughout the episode in the event of data collection that occurs prior to discharge. Up to eight codes may be collected. Within a computerised information system the detailed activities can be mapped to the CNMDSA interventions enabling the option of a rich level of detail of activities or summarised information.

Related data: relates to the data element Nursing goal, version 1
supersedes previous data element Nursing interventions, version 1
relates to the data element Nursing diagnosis, version 2

Administrative attributes

Source document:

Source organisation: Australian Council of Community Nursing Services

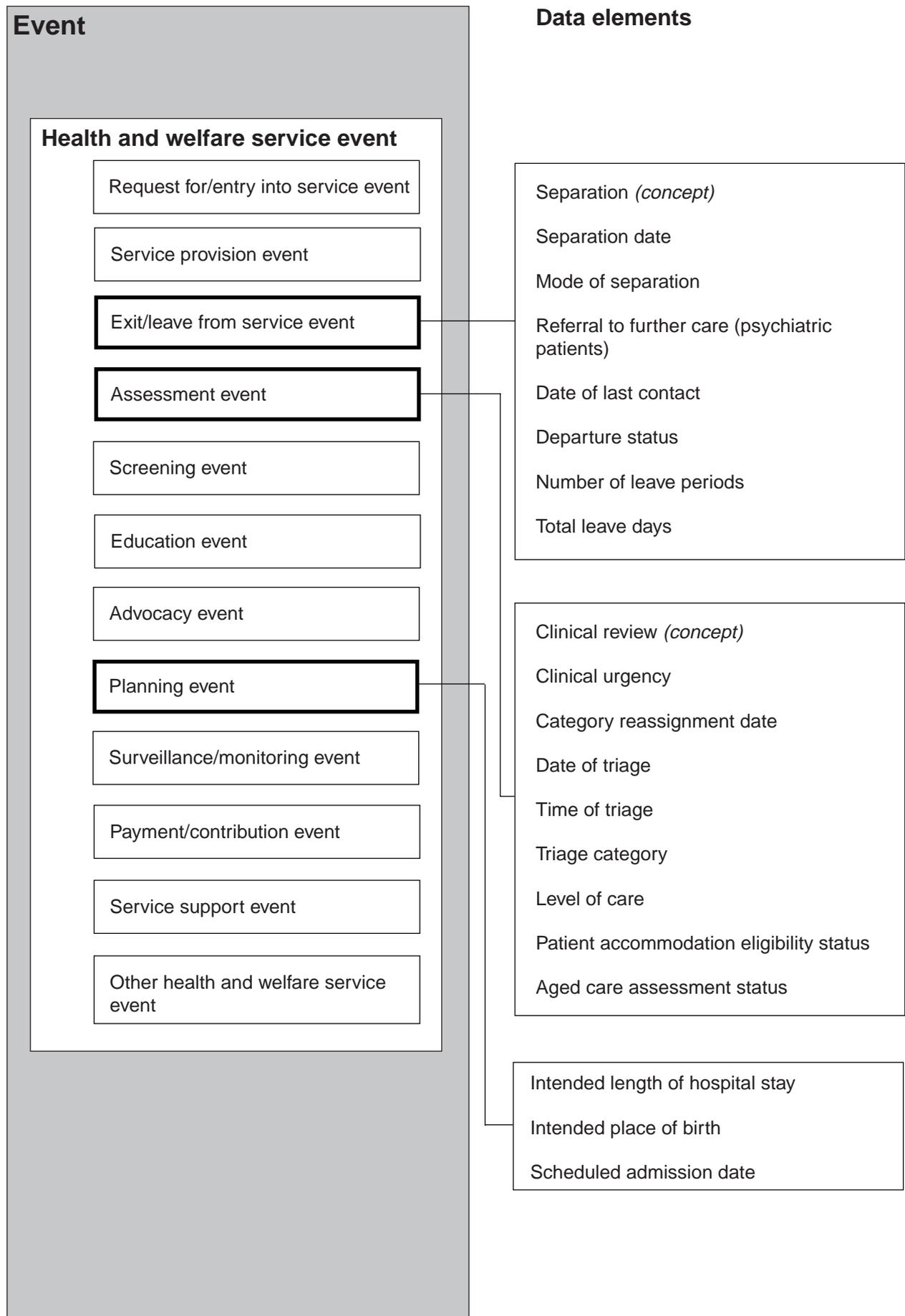
National minimum data sets:

Comments: The CNMDSA Nursing interventions are summary information overlying the detailed nursing activity usually included in an agency data collection. They are not intended as a description of nursing activities in the CNMDSA. For instance, Technical nursing treatment or Procedure is the generic term for a broad range of nursing activities such as: medication administration and wound care management.

Collection of this information at discharge carries with it the expectation that nursing records will lend themselves to this level of summarisation of the care episode. The selection of eight interventions if more are specified is a potentially subjective task unless the nursing record is structured and clear enough to enable such a selection against the reasons for admission to care, and the major focus of care delivery. Clearly, the task is easier if ongoing automated recording of interventions within an agency information system enables discharge reporting of all interventions and their frequency, over a care episode.

Those agencies providing allied health services may wish to use the Physiotherapy and Occupational Therapy Interventions developed in conjunction with the National Centre for Classification in Health in addition to the CNMDSA Nursing interventions or other more relevant code sets.

National Health Information Model entities



Separation

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000148 *Version number:* 2

Data element type: DATA ELEMENT CONCEPT

Definition: The process by which an admitted patient completes an episode of care. A separation may be formal or statistical.

Formal separation: The administrative process by which a hospital records the completion of treatment and/or care and accommodation of a patient.

Statistical separation (on type change): The administrative process by which a hospital records the completion of an episode of care for a patient within the one hospital stay.

Context: Institutional health care

Relational and representational attributes

Datatype: *Representational form:*

Field size: *Min.* *Max.* *Representational layout:*

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data: supersedes previous data element Separation, version 1

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Comments: While this concept is also applicable to non-institutional health care and welfare services, different terminology to 'separation' is often used in these other care settings.

Separation date

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000043 *Version number:* 5

Data element type: DATA ELEMENT

Definition: Date on which an admitted patient completes an episode of care.

Context: Institutional health care: required to identify the period in which an admitted patient hospital stay or episode occurred and for derivation of length of stay.

Relational and representational attributes

Datatype: Numeric *Representational form:* DATE

Field size: *Min.* 8 *Max.* 8 *Representational layout:* DDMMYYYY

Data domain: Valid dates

Guide for use:

Verification rules: For the provision of State and Territory hospital data to Commonwealth agencies this field must:

- be <= last day of financial year
- be >= first day of financial year
- be >= Admission date

Collection methods:

Related data: supersedes previous data element Discharge date, version 4

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care	from 1/07/99 to
Institutional mental health care	from 1/07/99 to
Palliative care	from 1/07/2000 to

Comments: There may be variations amongst jurisdictions with respect to the recording of separation date. This most often occurs for patients who are statistically separated after a period of leave (and who do not return for further hospital care). In this case, some jurisdictions may record the separation date as the date of statistical separation (and record intervening days as leave days) while other jurisdictions may retrospectively separate patients on the first day of leave. Despite the variations in recording of separation date for this group of patients, the current practices provide for the accurate recording of length of stay.

Mode of separation

Admin. status: CURRENT 1/07/93

Identifying and definitional attributes

Knowledgebase ID: 000096 *Version number:* 2

Data element type: DATA ELEMENT

Definition: Status at separation of person (discharge/transfer/death) and place to which person is released (where applicable).

Context: Institutional health care: required for outcome analyses, for analyses of intersectoral patient flows and to assist in the continuity of care and classification of episodes into Diagnosis Related Groups.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1	Discharge/transfer to an(other) acute hospital
2	Discharge/transfer to a nursing home
3	Discharge/transfer to an(other) psychiatric hospital
4	Discharge/transfer to other health care accommodation (includes mothercraft hospitals and hostels recognised by the Commonwealth Department of Health and Aged Care, unless this is the usual place of residence)
5	Statistical discharge – type change
6	Left against medical advice/discharge at own risk
7	Statistical discharge from leave
8	Died
9	Other (includes discharge to usual residence/own accommodation/welfare institution (includes prisons, hostels and group homes providing primarily welfare services))

Guide for use: For Code 4 – In jurisdictions where mothercraft facilities are considered to be acute hospitals, patients separated to a mothercraft facility should have a mode of separation of Code 1.

Verification rules:

Collection methods:

Related data:

- is supplemented by the data element Source of referral to public psychiatric hospital, version 3
- is supplemented by the data element Source of referral to acute hospital or private psychiatric hospital, version 3
- supersedes previous data element Mode of separation, version 1
- is used in the derivation of Diagnosis related group, version 1

Mode of separation (*continued*)

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care	from 1/07/89 to
Institutional mental health care	from 1/07/97 to
Palliative care	from 1/07/2000 to

Comments: The terminology of the modes relating to statistical separation have been modified to be consistent with the changes to data element Type of episode of care and other data elements related to admissions and separations.

During 1999, the National Mental Health Information Strategy Committee is reviewing a draft data element 'Referral to further care' which will involve a review of the data element Mode of separation.

Referral to further care (psychiatric patients)

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000143 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Referral to further care by health service agencies/facilities.

Context: Mental health care: many psychiatric inpatients have continuing needs for post-discharge care. Continuity of care across the hospital-community interface is a key policy theme emerging in the various States and Territories. Inclusion of this item allows the opportunity to monitor interagency linkages and is complementary to the data element Source of referral.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1	Not referred
2	Private psychiatrist
3	Other private medical practitioner
4	Mental health / alcohol and drug in-patient facility
5	Mental health / alcohol and drug non in-patient facility
6	Acute hospital
7	Other

Guide for use:

Verification rules:

Collection methods:

Related data:

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

Comments: This data element will be reviewed during 1999.

Date of last contact

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000040 *Version number:* 2

Data element type: DATA ELEMENT

Definition: Date of the last contact between a staff member of the community service and a person in any setting.

The definition includes:

- visits made to persons in institutional settings for the purpose of handing over or otherwise completing a care episode;
- bereavement visits in any setting;
- visits made to the person's home to complete the service, including the collection of equipment.

The definition excludes:

- visits made by liaison/discharge planning staff of a community service for the purpose of assessment of need related to a subsequent episode of care.

Context: To enable analysis of time periods throughout a care episode, especially the bereavement period. This date has been included in order to capture the end of a care episode in terms of involvement of the community nursing service.

Relational and representational attributes

Datatype: Numeric *Representational form:* DATE

Field size: *Min.* 8 *Max.* 8 *Representational layout:* DDMMYYYY

Data domain: Valid dates

Guide for use: This could be the same as the date of discharge.

Verification rules: May occur after or on the same day as Date of last delivery of service

Collection methods:

Related data: supersedes previous data element Date of last community service contact with client/family, version 1

relates to the data element Date of first contact, version 2

Administrative attributes

Source document:

Source organisation: Australian Council of Community Nursing Services

National minimum data sets:

Comments: Although the data item has Recommended status only, if service agencies are committed to monitoring all resource utilisation associated with an episode of care, this post-discharge date and the corresponding pre-admission item Date of first contact, have a place within an agency information system. This is particularly true for those agencies providing discharge planning service or specialist consultancy or assessment services.

Departure status

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000359 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The status of the patient on departure from the Emergency Department.

Context: Institutional health care: Required for analysis of client care.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1	Admitted to ward or other admitted patient unit (includes patients who may have been in observation area in Emergency Department prior to admission).
2	Emergency department service event completed, departed under own care.
3	Transferred to another hospital for admission.
4	Did not wait to be attended (by medical officer).
5	Left at own risk, after medical officer assumed responsibility for the patient but before Emergency Department service event was completed.
6	Died in Emergency Department.
7	Dead on arrival, not treated in Emergency Department.

Guide for use:

Verification rules:

Collection methods:

Related data:

- relates to the data element Admission date, version 4
- relates to the data element Emergency Department waiting time to service delivery, version 1
- relates to the data element Emergency Department waiting time to admission, version 1
- relates to the data element concept Patient presentation at Emergency Department, version 1
- relates to the data element Date patient presents, version 1
- relates to the data element Time patient presents, version 1
- relates to the data element Type of visit, version 1
- relates to the data element Date of triage, version 1
- relates to the data element Time of triage, version 1
- relates to the data element Triage category, version 1

Departure status (*continued*)

Related data (cont'd): relates to the data element Date of service event, version 1

relates to the data element Time of service event, version 1

relates to the data element Admission time, version 1

Administrative attributes

Source document:

Source organisation: National Institution Based Ambulatory Model Reference Group; National Health Data Committee

National minimum data sets:

Emergency Department waiting times from 1/07/99 to

Comments: This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department Waiting Times National Minimum Data Set.

Number of leave periods

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000107 *Version number:* 3

Data element type: DATA ELEMENT

Definition: Number of leave periods in a hospital stay (excluding one-day leave periods for admitted patients).

Leave period is a temporary absence from hospital, with medical approval for a period no greater than seven consecutive days.

Context: Institutional health care: recording of leave periods allows for the calculation of patient days excluding leave. This is important for analysis of costs per patient and for planning. The maximum limit allowed for leave affects admission and separation rates, particularly for long-stay patients who may have several leave periods.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 2 *Representational layout:* NN

Data domain: Count is number of days

Guide for use: If the period of leave is greater than seven days or of the patient fails to return from leave, the patient is discharged.

Verification rules:

Collection methods:

Related data: is used in the derivation of Length of stay, version 1
supersedes previous data element Number of leave periods, version 2

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Institutional mental health care from 1/07/97 to

Comments: This data element was modified in July 1996 to exclude the previous differentiation between the psychiatric and other patients at the instigation of the National Mental Health Strategy Committee.

Total leave days

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000163 *Version number:* 3

Data element type: DATA ELEMENT

Definition: Sum of the length of leave (date returned from leave minus date went on leave) for all periods within the hospital stay.

Context: Institutional health care: recording of leave days allows for exclusion of these from the calculation of patient days. This is important for analysis of costs per patient and for planning. The maximum limit allowed for leave affects admission and separation rates, particularly for long-stay patients who may have several leave periods.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 3 *Representational layout:* NNN

Data domain: Count is number of days

Guide for use: A day is measured from midnight to midnight.

The following rules apply in the calculation of leave days for both overnight and same-day patients:

- The day the patient goes on leave is counted as a leave day.
- The day the patient is on leave is counted as a leave day.
- The day the patient returns from leave is counted as a patient day.
- If the patient is admitted and goes on leave on the same day, this is counted as a patient day, not a leave day.
- If the patient returns from leave and then goes on leave again on the same day, this is counted as a leave day.
- If the patient returns from leave and is separated on the same day, the day should not be counted as either a patient day or a leave day.

Verification rules: For the provision of State and Territory hospital data to Commonwealth agencies (Date of separation minus Date of admission) minus Total leave days must be ≥ 0 days.

Collection methods:

Related data: supersedes previous data element Total leave days, version 2

Administrative attributes

Source document:

Source organisation: National Health Data Committee

Total leave days (*continued*)

National minimum data sets:

Institutional health care from 1/07/89 to

Institutional mental health care from 1/07/97 to

Comments: It should be noted that for private patients in public and private hospitals, s.3 (12) of the Health Insurance Act 1973 (Cwlth) currently applies a different leave day count, Commonwealth Department of Human Services and Health HBF Circular 354 (31 March 1994).

This item was modified in July 1996 to exclude the previous differentiation between the psychiatric and other patients.

Clinical review

Admin. status: CURRENT 1/07/95

Identifying and definitional attributes

Knowledgebase ID: 000024 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

Definition: The examination of a patient by a clinician after the patient has been added to the waiting list. This examination may result in the patient being assigned a different urgency rating from the initial classification. The need for clinical review varies with a patient's condition and is therefore at the discretion of the treating clinician.

Context: Institutional health care

Relational and representational attributes

Datatype: *Representational form:*

Field size: *Min.* *Max.* *Representational layout:*

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data: relates to the data element Clinical urgency, version 1

relates to the data element Clinical urgency, version 2

Administrative attributes

Source document:

Source organisation: Hospital Access Program Waiting List Working Group / National Health Data Committee

National minimum data sets:

Elective surgery waiting times from 1/07/94 to

Comments:

Clinical urgency

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000025 *Version number:* 2

Data element type: DATA ELEMENT

Definition: A clinical assessment of the urgency with which a patient requires elective hospital care.

Context: Elective surgery: categorisation of waiting list patients by clinical urgency assists hospital management and clinicians in the prioritisation of their workloads. It gives health consumers a reasonable estimate of the maximum time they should expect to wait for care.

Clinical urgency classification allows a meaningful measure of system performance to be calculated, namely the number or proportion of patients who wait for times in excess of the maximum desirable time limit for their urgency category (data element 'Overdue patient').

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1	Admission within 30 days desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency
2	Admission within 90 days desirable for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly or become an emergency
3	Admission at some time in the future acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency

Guide for use: The classification employs a system of urgency categorisation based on factors such as the degree of pain, dysfunction and disability caused by the condition and its potential to deteriorate quickly into an emergency. All patients ready for care must be assigned to one of the urgency categories, regardless of how long it is estimated they will need to wait for surgery.

Verification rules:

Collection methods:

Related data:

- relates to the data element concept Clinical review, version 1
- supersedes previous data element Patient listing status, version 2
- is used in conjunction with Patient listing status, version 3
- is used in conjunction with Category reassignment date, version 2
- is a qualifier of Overdue patient, version 3

Clinical urgency (*continued*)

Related data (cont'd): is a qualifier of Extended wait patient, version 1
is a qualifier of Waiting time at a census date, version 1
is a qualifier of Waiting time at admission, version 1

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Elective surgery waiting times from 1/07/94 to

Comments: A patient's classification may change if he or she undergoes clinical review during the waiting period. The need for clinical review varies with the patient's condition and is therefore at the discretion of the treating clinician. The waiting list information system should be able to record dates when the classification is changed (data element Category reassignment date).

Category reassignment date

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000391 *Version number:* 2

Data element type: DATA ELEMENT

Definition: The date on which a patient awaiting elective hospital care is assigned to a different urgency category as a result of clinical review for the awaited procedure, or is assigned to a different patient listing status category ('ready for care' or 'not ready for care').

Context: Elective surgery: this date is necessary for the calculation of Waiting time at admission and Waiting time at a census date.

Relational and representational attributes

Datatype: Numeric *Representational form:* DATE

Field size: *Min.* 8 *Max.* 8 *Representational layout:* DDMMYYYY

Data domain:

Guide for use: The date needs to be recorded each time a patient's urgency classification or listing status changes.

Verification rules:

Collection methods:

Related data: relates to the data element Clinical review, version 1
is used in conjunction with Patient listing status, version 3
is used in conjunction with Clinical urgency, version 2
supersedes previous data element Urgency reassignment date, version 1
is used in the calculation of Waiting time at a census date, version 1
is used in the calculation of Waiting time at admission, version 1

Administrative attributes

Source document:

Source organisation: Australian Institute of Health and Welfare, National Health Data Committee

National minimum data sets:

Elective surgery waiting times from 1/07/94 to

Comments:

Date of triage

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000353 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The day on which the patient is triaged.

Context: Institutional health care: Required to identify the commencement of the service and calculation of waiting times.

Relational and representational attributes

Datatype: Numeric *Representational form:* DATE

Field size: *Min.* 8 *Max.* 8 *Representational layout:* DDMMYYYY

Data domain: Valid dates

Guide for use:

Verification rules:

Collection methods:

Related data: relates to the data element Emergency Department waiting time to service delivery, version 1

relates to the data element concept Patient presentation at Emergency Department, version 1

relates to the data element Time of triage, version 1

Administrative attributes

Source document:

Source organisation: National Institution Based Ambulatory Model Reference Group; National Health Data Committee

National minimum data sets:

Emergency Department waiting times from 1/07/99 to

Comments: This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department Waiting Times National Minimum Data Set.

Time of triage

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000354 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The time at which the patient is triaged.

Context: Institutional health care: Required to identify the commencement of the service and calculation of waiting times.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 4 *Max.* 4 *Representational layout:* HHMM

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data:

- relates to the data element Admission date, version 4
- relates to the data element Emergency Department waiting time to service delivery, version 1
- relates to the data element Emergency Department waiting time to admission, version 1
- relates to the data element concept Patient presentation at Emergency Department, version 1
- relates to the data element Date patient presents, version 1
- relates to the data element Time patient presents, version 1
- relates to the data element Type of visit, version 1
- relates to the data element Date of triage, version 1
- relates to the data element Triage category, version 1
- relates to the data element Date of service event, version 1
- relates to the data element Time of service event, version 1
- relates to the data element Admission time, version 1

Administrative attributes

Source document:

Source organisation: National Institution Based Ambulatory Model Reference Group; National Health Data Committee

National minimum data sets:

Emergency Department waiting times from 1/07/99 to

Comments: This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department Waiting Times National Minimum Data Set.

Triage category

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000355 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The urgency of the patient's need for medical and nursing care.

Context: Institutional healthcare: Required to provide data for analysis of Emergency Department processes.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1	Resuscitation: Immediate (within seconds)
2	Emergency: Within 10 minutes
3	Urgent: Within 30 minutes
4	Semi-urgent: Within 60 minutes
5	Non-urgent: Within 120 minutes

Guide for use:

Verification rules:

Collection methods: This triage classification is to be used in the Emergency Departments of hospitals. Patients will be triaged into one of five categories on the National Triage Scale according to the triageur's response to the question: 'This patient should wait for medical care no longer than ...?'

The triage category is allocated by an experienced registered nurse or medical practitioner. If the triage category changes, record the more urgent category.

Related data:

- relates to the data element Non-admitted patient, version 1
- relates to the data element Admission date, version 4
- supersedes previous data element Triage category (trial), version 1
- relates to the data element Emergency Department waiting time to service delivery, version 1
- relates to the data element Emergency Department waiting time to admission, version 1
- relates to the data element concept Patient presentation at Emergency Department, version 1
- relates to the data element Date patient presents, version 1
- relates to the data element Time patient presents, version 1
- relates to the data element Type of visit, version 1
- relates to the data element Date of triage, version 1

Triage category (*continued*)

Related data (cont'd): relates to the data element Time of triage, version 1
relates to the data element Date of service event, version 1
relates to the data element Time of service event, version 1
relates to the data element Admission time, version 1
relates to the data element Departure status, version 1

Administrative attributes

Source document: National Triage Scale, Australasian College for Emergency Medicine (ACEM)

Source organisation:

National minimum data sets:

Emergency Department waiting times from 1/07/99 to

Comments: This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department Waiting Times National Minimum Data Set.

Level of care

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000294 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The level of care needed by a patient / resident as assessed by the summation of scores on questions contained in the Resident Classification Instrument and subsequent classification into one of five major categories.

Context: Nursing homes: the level of resources and associated costs of providing care to nursing home residents depends on the levels of dependency of the residents. This field is an attempt to measure the levels of care required by individual residents in order that an overall profile of the nursing home population can be obtained. Such a profile is necessary to help explain cost variations both between nursing homes and over time.

At present there is no method of determining the underlying population demand for nursing home beds. changes on the level of care required on admission to a nursing home may also provide a useful indication of changes in demand.

This data element also provides a summary profile of dependency of resident population, as a basis for monitoring changes in resident profile as a consequence of assessment and other measures being introduced.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1	Very high need
2	High need
3	Medium need
4	Low need
5	Very low need
6	Ordinary care (non-RCI)
7	Extensive care (non-RCI)

Guide for use: For State nursing homes not using Resident Classification Instrument, the level of care as measured by resident classification into ordinary of extensive care.

Verification rules:

Collection methods: This item is based on the Resident Classification Instrument, which has been replaced.

Related data:

Administrative attributes

Source document:

Level of care (*continued*)

Source organisation: National minimum data set working parties

National minimum data sets:

Comments: This data element is subject to review during 1999.

Patient accommodation eligibility status

Admin. status: CURRENT 1/07/93

Identifying and definitional attributes

Knowledgebase ID: 000118 *Version number:* 2

Data element type: DATA ELEMENT

Definition: An eligible person means:

- a person who resides in Australia and whose stay in Australia is not subject to any limitation as to time imposed by law; but

- does not include a foreign diplomat or family (except where eligibility is expressly granted to such persons by the terms of a reciprocal health care agreement); or

- persons visiting Australia who are ordinarily resident in the United Kingdom, New Zealand, Sweden, Malta, Italy and the Netherlands are covered by reciprocal health care agreements. However, persons from Malta or Italy are covered for six months only.

Eligible persons must enrol with Medicare before benefits can be paid.

Context: Health services: to facilitate analyses of hospital utilisation and policy relating to health care financing.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1	Eligible public patient
2	Eligible private patient
3	Eligible Department of Veteran's Affairs patient
4	Eligible other patient
5	Ineligible patient

Guide for use: Eligible

Public patient:

- an eligible person who, on admission to a recognised hospital or soon after, elects to be a public patient; or

- an eligible public patient whose treatment is contracted to a private hospital.

A public patient shall be entitled to receive the care and treatment referred to in accordance with the Australian Health Care Agreements without charge.

Private patient:

- an eligible person who, on admission to a recognised hospital or soon after, elects to be a private patient treated by a medical practitioner of his or her choice; or elects to occupy a bed in a single room. Where such an election is made, the patient is responsible for meeting certain hospital charges as well as the professional charges raised by any treating medical or dental practitioner.

Patient accommodation eligibility status (*continued*)

Guide for use (cont'd): or

- an eligible person who chooses to be admitted to a private hospital. Where such a choice is made, the patient is responsible for meeting all hospital charges as well as the professional charges raised by any treating medical or dental practitioner.

Department of Veterans' Affairs patient: an eligible person whose charges for this hospital admission are met by the Department of Veterans' Affairs.

Other patient: an eligible patient who does not meet the criteria for above categories; that is, not an eligible public patient, not an eligible private patient or an eligible Department of Veterans' Affairs patient. This category includes compensable patients, patients with Defence Force personnel entitlements and common law cases.

Ineligible

A person who is not eligible under Medicare.

Verification rules:

Collection methods: It is recognised that a patient's accommodation status may change during the hospital stay, and it is therefore recommended that this item be recorded on separation from hospital.

It is recognised that ineligible patients may be treated as public or private patients, but for data set purposes at the present time this is not considered significant. Individual State and Territory collections may record this additional detail.

Related data: supersedes previous data element Patient accommodation status, version 1
is used in conjunction with Compensable status, version 2
is used in conjunction with Insurance status, version 2
is used in conjunction with Type of episode of care, version 3

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Institutional mental health care from 1/07/97 to

Comments:

Aged care assessment status

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000017 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The assessment status of a person in terms of whether or not he or she has been assessed by a regional aged care assessment team and, if so, which one.

Context: Aged care assessment: useful variable when comparing resident population across systems.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1	Assessed by approved aged care assessment team
2	Assessed by non-approved aged care assessment team
3	Assessed by Commonwealth medical officer
4	Not assessed
5	Unknown

Guide for use:

Verification rules:

Collection methods: This item is based on the form NH5, which has been replaced.

Related data:

Administrative attributes

Source document:

Source organisation: Commonwealth Department of Health and Aged Care

National minimum data sets:

Comments: This data element is subject to review during 1999.

Intended length of hospital stay

Admin. status: CURRENT 1/07/94

Identifying and definitional attributes

Knowledgebase ID: 000076 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The intention of the responsible clinician at the time of the patient's admission to hospital, to discharge the patient either on the day of admission or a subsequent date.

Context: Institutional health care: to assist in the identification and casemix analysis of planned same-day patients, that is those patients who are admitted with the intention of discharge on the same day. This is also a key indicator for quality assurance activities.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain: 1 Intended same-day
2 Intended overnight

Guide for use:

Verification rules:

Collection methods: The intended length of stay should be ascertained for all admitted patients at the time the patient is admitted to hospital.

Related data: is used in the derivation of Diagnosis related group, version 1

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Comments: Information comparing the intended length of the episode of care and the actual length of the episode of care is considered useful for quality assurance and utilisation review purposes.

Intended place of birth

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000077 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The intended place of birth at the onset of labour.

Context: Perinatal statistics: mothers who plan to give birth in birth centres or at home usually have different risk factors for outcome compared to those who plan to give birth in hospitals. Those mothers who are transferred to hospital after the onset of labour have increased risks of intervention and adverse outcomes.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1	Hospital
2	Birth centre, attached to hospital
3	Birth centre, free standing
4	Home
8	Other
9	Not stated

Guide for use:

Verification rules:

Collection methods:

Related data: is qualified by Actual place of birth, version 1

Administrative attributes

Source document:

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Comments: The development of a definition of a birth centre is currently under consideration by the Commonwealth in conjunction with the States and Territories.

Scheduled admission date

Admin. status: CURRENT 1/01/95

Identifying and definitional attributes

Knowledgebase ID: 000147 *Version number:* 2

Data element type: DATA ELEMENT

Definition: The date on which it is proposed that a patient on the waiting list will be admitted for an episode of care.

Context: This item is required for the purposes of hospital management – allocation of beds, operating theatre time and other resources.

Relational and representational attributes

Datatype: Numeric *Representational form:* DATE

Field size: *Min.* 8 *Max.* 8 *Representational layout:* DDMMYYYY

Data domain: Valid dates

Guide for use:

Verification rules:

Collection methods:

Related data: supersedes previous data element Scheduled admission date, version 1
is used in conjunction with Listing date, version 2

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Comments: If this data element were to be used to compare different hospitals or geographical locations, it would be necessary to specify when the scheduled date is to be allocated (for example, on addition to the waiting list).

National Health Information Model entities

Business factors

Business statement

Health and welfare
policy planHealth and welfare policy/plan
element

Vision/mission

Goal/objective

Priority

Performance indicator

Other policy/plan element

Data elements

Hospital census (*concept*)

Census date

Extended wait patient

Overdue patient

Waiting time at a census date

Waiting time at admission

Patient days

Total psychiatric care days

Type of admitted patient care for long-stay
patientsType of admitted patient care for overnight
patientsType of admitted patient care for same-day
patientsType of admitted patient care for short-stay
patients

Type of non-admitted patient care

Type of non-admitted patient care (nursing
homes and hostels)Type of non-admitted patient care (public
psychiatric, alcohol and drug)

Patients in residence at year end

Separations

Emergency Department waiting time to
admissionEmergency Department waiting time to service
delivery

Occasions of service

Length of stay

Number of acute (qualified) /unqualified days
for newborns

Hospital census

Admin. status: CURRENT 1/01/95

Identifying and definitional attributes

Knowledgebase ID: 000066 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

Definition: A point in time count by a hospital of all its admitted patients and/or patients currently on a waiting list.

Context: Institutional health care

Relational and representational attributes

Datatype: *Representational form:*

Field size: *Min.* *Max.* *Representational layout:*

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data: relates to the data element Census date, version 2

relates to the data element Waiting time at a census date, version 1

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

Elective surgery waiting times from 1/07/94 to

Comments:

Census date

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000174 *Version number:* 2

Data element type: DATA ELEMENT

Definition: Date on which the hospital takes a point in time (census) count of and characterisation of patients on the waiting list.

Context: Elective surgery: this data element is necessary for the calculation of the waiting time until a census.

Relational and representational attributes

Datatype: Numeric *Representational form:* DATE

Field size: *Min.* 8 *Max.* 8 *Representational layout:* DDMMYYYY

Data domain:

Guide for use: This date is recorded when a census is done of the patients on a waiting list.

Verification rules:

Collection methods:

Related data: supersedes previous data element Census date, version 1
is used in the calculation of Waiting time at a census date, version 1

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Elective surgery waiting times from 1/07/94 to

Comments:

Extended wait patient

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000400 *Version number:* 1

Data element type: DERIVED DATA ELEMENT

Definition: A patient with the lowest level of clinical urgency for an awaited procedure who has been on the waiting list for elective surgery for more than one year.

Context: Elective surgery: the numbers and proportions of patients with extended waits are measures of hospital performance in relation to patient access to elective hospital care.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:
1 Extended wait patient
2 Other patient

Guide for use: A patient is classified as an extended wait patient if the patient is in clinical urgency category 3 at the time of admission or at a census time and has been waiting for the elective surgery for more than one year.

Verification rules:

Collection methods:

Related data:
is qualified by Clinical urgency, version 2
is derived from Waiting time at a census date, version 1
is derived from Waiting time at admission, version 1

Administrative attributes

Source document:

Source organisation: Australian Institute of Health and Welfare, National Health Data Committee

National minimum data sets:

Elective surgery waiting times from 1/07/99 to

Comments: This data item is used to identify clinical urgency category 3 patients who had waited longer than one year at admission or have waited longer than one year at the time of a census. An extended wait patient is not an 'Overdue patient' as there is no maximum desirable waiting time specified for patients in clinical urgency category 3 as they have been assessed as not having a clinically urgent need for the awaited procedure.

Overdue patient

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000085 *Version number:* 3

Data element type: DERIVED DATA ELEMENT

Definition: An overdue patient is one whose wait has exceeded the time that has been determined as clinically desirable in relation to the urgency category to which they have been assigned.

Context: Elective surgery: the numbers and proportions of overdue patients represent a measure of the hospital's performance in provision of elective hospital care.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1	Overdue patient
2	Other

Guide for use: This data element is only required for patients in clinical urgency categories with specified maximum desirable waiting times. Overdue patients are those for whom the hospital system has failed to provide timely care and whose wait may have an adverse effect on the outcome of their care. They are identified by a comparison of 'Waiting time at admission' or 'Waiting time at a census date' and the maximum desirable time limit for the 'Clinical urgency' classification.

A patient is classified as overdue if ready for care and 'Waiting time at admission' or 'Waiting time at a census date' is longer than 30 days for patients in Clinical urgency category 1 or 90 days for patients in Clinical urgency category 2.

Verification rules:

Collection methods:

Related data:

- supersedes previous data element Overdue patient, version 2
- is qualified by Clinical urgency, version 2
- is derived from Waiting time at a census date, version 1
- is derived from Waiting time at admission, version 1

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Elective surgery waiting times from 1/07/94 to

Overdue patient (*continued*)

Comments: This data item is not used for patients in Clinical urgency category 3 as there is no specified timeframe within which it is desirable that they are admitted. The data element Extended wait patient identifies patients in Clinical urgency category 3 who have waited longer than one year at admission or at the time of a census.

Waiting time at a census date

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000412 *Version number:* 1

Data element type: DERIVED DATA ELEMENT

Definition: The time elapsed for a patient on the elective surgery waiting list from the date they were added to the waiting list for the procedure to a designated census date.

Context: Elective surgery: this is a critical elective surgery waiting times data element. It is used to determine whether patients are overdue, or had extended waits at a census date. It is used to assist doctors and patients in making decisions about hospital referral, to assist in the planning and management of hospitals and in health care related research.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 4 *Representational layout:* NNNN

Data domain: Count in number of days

Guide for use: The number of days is calculated by subtracting the Listing Date from the Census date, minus any days when the patient was 'not ready for care', and also minus any days the patient was waiting with a lower clinical urgency category than their clinical urgency category at the Census date.

Days when the patient was not ready for care is calculated by subtracting the date(s) the person was recorded as 'not ready for care' from the date(s) the person was subsequently recorded as again being 'ready for care'

If, at any time since being added to the waiting list for the elective surgical procedure, the patient has had a lower clinical urgency category than the category at the Census date, then the number of days waited at the lower clinical urgency category should be subtracted from the total number of days waited.

In cases where there has been only one category reassignment (ie. to the higher category attached to the patient at Census date) the number of days at the lower clinical urgency category should be calculated by subtracting the Listing date from the Category reassignment date. If the patient's clinical urgency was reclassified more than once, days spent in each period of lower clinical urgency than the one applying at the Census date should be calculated by subtracting one Category reassignment date from the subsequent Category reassignment date, and then added together.

Verification rules:

Collection methods:

Related data: is calculated using Listing date, version 2
is calculated using Census date, version 2
is calculated using Patient listing status, version 3

Waiting time at a census date (*continued*)

Related data (cont'd): is qualified by Clinical urgency, version 2
is calculated using Category reassignment date, version 2
is used in the derivation of Overdue patient, version 3
is used in the derivation of Extended wait patient, version 1

Administrative attributes

Source document:

Source organisation: Australian Institute of Health and Welfare, National Health Data Committee

National minimum data sets:

Elective surgery waiting times from 1/07/99 to

Comments: Elective surgery waiting times data collections include measures of waiting times at admission and at designated census dates. This data element is used to measure waiting times at a designated census date whereas the data element Waiting time at admission measures waiting times at admission.

Waiting time at admission

Admin. status: CURRENT 1/07/99

Identifying and definitional attributes

Knowledgebase ID: 000413 *Version number:* 1

Data element type: DERIVED DATA ELEMENT

Definition: The time elapsed for a patient on the elective surgery waiting list from the date they were added to the waiting list for the procedure to the date they were admitted to hospital for the procedure.

Context: Elective surgery: this is a critical elective surgery waiting times data element. It is used to determine whether patients are overdue, or had extended waits at admission. It is used to assist doctors and patients in making decisions about hospital referral, to assist in the planning and management of hospitals and in health care related research.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 4 *Representational layout:* NNNN

Data domain: Count in number of days

Guide for use: The number of days is calculated by subtracting the Listing Date from the Admission date, minus any days when the patient was 'not ready for care', and also minus any days the patient was waiting with a lower clinical urgency category than their clinical urgency category at admission.

Days when the patient was not ready for care is calculated by subtracting the date(s) the person was recorded as 'not ready for care' from the date(s) the person was subsequently recorded as again being 'ready for care'.

If, at any time since being added to the waiting list for the elective surgical procedure, the patient has had a lower clinical urgency category than the category at admission, then the number of days waited at the lower clinical urgency category should be subtracted from the total number of days waited.

In cases where there has been only one category reassignment (i.e. to the higher category attached to the patient at admission) the number of days at the lower clinical urgency category should be calculated by subtracting the Listing date from the Category reassignment date. If the patient's clinical urgency was reclassified more than once, days spent in each period of lower clinical urgency than the one applying at admission should be calculated by subtracting one Category reassignment date from the subsequent Category reassignment date, and then added together.

Verification rules:

Collection methods:

Related data: is calculated using Listing date, version 2
is calculated using Patient listing status, version 3
is qualified by Clinical urgency, version 2

Waiting time at admission (*continued*)

Related data (cont'd): is calculated using Category reassignment date, version 2
is used in the derivation of Overdue patient, version 3
is used in the derivation of Extended wait patient, version 1
is calculated using Admission date, version 4

Administrative attributes

Source document:

Source organisation: Australian Institute of Health and Welfare, National Health Data Committee

National minimum data sets:

Elective surgery waiting times from 1/07/99 to

Comments: Elective surgery waiting times data collections include measures of waiting times at admission and at designated census dates. This data element is used to measure waiting times at admission whereas the data element Waiting time at census date measures waiting times at a designated census date.

Patient days

Admin. status: CURRENT 1/07/95

Identifying and definitional attributes

Knowledgebase ID: 000206 *Version number:* 2

Data element type: DERIVED DATA ELEMENT

Definition: The number of patient days is the total number of days or part days of stay for all patients who were admitted for an episode of care and who underwent separation during a specified reference period.

Context: Admitted patient care: needed as the basic count of the number of services provided by an establishment.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 8 *Representational layout:* NNNNNNNN

Data domain: Total patient days for the period

Guide for use: A day is measured from midnight to midnight.

The following rules are used to calculate the number of patient days for both overnight and same-day patients:

- The day the patient is admitted is a patient day.
- The day the patient is discharged is not counted as a patient day (unless the patient was admitted and separated on the same date).
- Patients admitted and separated on the same date (same-day patients) are to be given a count of one day.
- The day a patient goes on leave is counted as a leave day.
- The day the patient returns from leave is counted as a patient day.
- If the patient is admitted and goes on leave on the same day, count as a patient day, not a leave day.
- If the patient returns from leave and is separated, it is not counted as either a patient day or a leave day.

All leave days are excluded from the patient days count except for the day the patient returns from leave.

Exclude patient days for those patients admitted during the specified reference period who did not undergo separation until the following reference period.

Verification rules:

Collection methods: For the national minimum data set – institutional health care the reference period for data collection is a financial year ie. 1 July to 30 June inclusive.

Related data: is derived from Admission date, version 4
is derived from Total leave days, version 3

Patient days (*continued*)

Related data (cont'd): supersedes previous data element Occupied bed days, version 1
is derived from Type of episode of care, version 3
is derived from Separation date, version 5

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Comments: It should be noted that for private patients in public and private hospitals, s.3(12) of the Health Insurance Act 1973 (Cwlth) currently applies a different leave day count (Commonwealth Department Human Services and Health HBF Circular 354 (31 March 1994)).

Total psychiatric care days

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000164 *Version number:* 2

Data element type: DERIVED DATA ELEMENT

Definition: The sum of the number of days or part days of stay that the person received care as an admitted patient or resident within a designated psychiatric unit, minus the sum of leave days occurring during the stay within the designated unit.

Context: Admitted patient and residential mental health care: this data element is required to identify the characteristics of patients treated in specialist psychiatric units located within acute care hospitals or 24-hour staffed community-based residential services and to analyse the activities of these units and services. Community mental health care: this data element is required to identify the characteristics of patients treated in specialist psychiatric 24-hour staffed community-based residential services and to analyse the activities of these units. The data element is necessary to describe and evaluate the progress of mainstreaming of mental health services.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 5 *Representational layout:* NNNNN

Data domain: Count in number of days

Guide for use: Designated psychiatric units are staffed by health professionals with specialist mental health qualifications or training and have as their principal function the treatment and care of patients affected by mental disorder. The unit may or may not be recognised under relevant State and Territory legislation to treat patients on an involuntary basis. Patients are admitted patients in the acute and psychiatric hospitals and residents in community based residences.

Public acute care hospitals

Designated psychiatric units in public acute care hospitals are normally recognised by the State/Territory health authority in the funding arrangements applying to those hospitals.

Private acute care hospitals

Designated psychiatric units in private acute care hospitals normally require license or approval by the State/Territory health authority in order to receive benefits from health funds for the provision of psychiatric care.

Psychiatric hospitals

Total psychiatric care days in stand-alone psychiatric hospitals are calculated by counting those days the patient received specialist psychiatric care. Leave days and days on which the patient was receiving other care (eg specialised intellectual ability or drug and alcohol care) should be excluded.

Total psychiatric care days (*continued*)

Guide for use (cont'd): Psychiatric hospitals are establishments devoted primarily to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders. Private hospitals formerly approved by the Commonwealth Department of Health under the Health Insurance Act 1973 (Cwlth) (now licensed/approved by each State/Territory health authority), catering primarily for patients with psychiatric or behavioural disorders are included in this category.

Community-based residential services

Designated psychiatric units refers to 24-hour staffed community-based residential units established in community settings that provide specialised treatment, rehabilitation or care for people affected by a mental illness or psychiatric disability. Special psychiatric units for the elderly are covered by this category, including psychogeriatric hostels or psychogeriatric nursing homes. Note that residences occupied by admitted patients located on hospital grounds, whether on the campus of a general or stand-alone psychiatric hospital, should be counted in the category of admitted patient services and not as community-based residential services.

Counting of patient days and leave days in designated psychiatric units should follow the standard definitions applying to these items.

- For each period of care in a designated psychiatric unit, total days is calculated by subtracting the date on which care commenced within the unit from the date on which the specialist unit care was completed, less any leave days that occurred during the period.

Total psychiatric care days in 24-hour community-based residential care are calculated by counting those days the patient received specialist psychiatric care. Leave days and days on which the patient was receiving other care (eg specialised intellectual ability or drug and alcohol care) should be excluded.

Admitted patients in acute care: Commencement of care within a designated psychiatric unit may be the same as the date the patient was admitted to the hospital, or occur subsequently, following transfer of the patient from another hospital ward. Where commencement of psychiatric care occurs by transfer from another ward, a new episode of care may be recorded, depending on whether the care type has changed (see data element 'Type of episode of care'). Completion of care within a designated psychiatric unit may be the same as the date the patient was discharged from the hospital, or occur prior to this on transfer of the patient to another hospital ward. Where completion of psychiatric care is followed by transfer to another hospital ward, a new episode of care may be recorded, depending on whether the care type has changed (see data element 'Type of episode of care'). Total psychiatric care days may cover one or more periods in a designated psychiatric unit within the overall hospital stay.

Accurate counting of total days in psychiatric care requires periods in designated psychiatric units to be identified in the person-level data collected by State or Territory health authorities. Several mechanisms exist for this data field to be implemented.

Total psychiatric care days (*continued*)

- Guide for use (cont'd):**
- Ideally, the new data field should be collected locally by hospitals and added to the unit record data provided to the relevant State/Territory health authority.
 - Acute care hospitals in most States and Territories include details of the wards in which the patient was accommodated in the unit record data provided to the health authority. Local knowledge should be used to identify designated psychiatric units within each hospital's ward codes, to allow total psychiatric care days to be calculated for each episode of care.
 - Acute care hospitals and 24-hour staffed community-based residential services should be identified separately at the level of the establishment.

Verification rules: Total days in psychiatric care must be:
—>= zero;
and—<= length of stay

Collection methods:

Related data:

- is derived from Admission date, version 4
- is derived from Total leave days, version 3
- supersedes previous data element Total psychiatric care days, version 1
- is derived from Establishment type, version 1
- is derived from Type of episode of care, version 3
- is derived from Separation date, version 5

Administrative attributes

Source document:

Source organisation: National Mental Health Information Strategy Committee

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 1/07/2000 to

Comments: This data element was originally designed to monitor trends in the delivery of psychiatric admitted patient care in acute care hospitals. It has been modified to enable collection of data in the community-based residential care sector. The data element is intended to improve understanding in this area and contribute to the ongoing evaluation of changes occurring in mental health services.

Type of admitted patient care for long stay patients

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000388 *Version number:* 3

Data element type: DERIVED DATA ELEMENT

Definition: The number of admitted patients separated following a length of stay greater than 35 days totalled for specified programs within an institution.

Context: Institutional health care: this variable is required to describe adequately which broad programs of health care are provided in the establishment. Although this classificatory variable can be derived from the person-level data, a detailed description of the desired categories has been included in the National Health Data Dictionary to facilitate the routine production of a set of descriptive statistics for each establishment.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 7 *Representational layout:* NNNNNNN

Data domain: Count the number of separations for each of the following categories:

Guide for use: A8.1 Mental health: all episodes with principal diagnosis of F00-F09, F20-F54, F56-F69 and F80-F99.

A8.2 Alcohol and drug: all episodes with a principal diagnosis F10-F19 and F55.

A8.11 Medical/surgical/obstetrics: balance of episodes.

New South Wales, Australian Capital Territory, Victoria and the Northern Territory implemented ICD-10-AM from 1 July 1998. Other States will implement ICD-10-AM from 1 July 1999.

Verification rules:

Collection methods: This data element is collected for public psychiatric and alcohol and drug hospitals only.

Related data: supersedes previous data element Type of admitted patient care for long stay patients – ICD-9-CM 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 minimum data sets:

Comments:

Type of admitted patient care for overnight patients

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000387 *Version number:* 3

Data element type: DERIVED DATA ELEMENT

Definition: The number of admitted patients who are separated after more than one day's stay totalled for specified programs within an institution.

Context: Institutional health care: this variable is required to describe adequately which broad programs of health care are provided in the establishment. Although this classificatory variable can be derived from the person-level data, a detailed description of the desired categories has been included in the National Health Data Dictionary to facilitate the routine production of a set of descriptive statistics for each establishment.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 7 *Representational layout:* NNNNNNN

Data domain: Count the number of separations for each of the following categories.

Guide for use: A8.1 Mental health: all episodes with principal diagnosis of F00-F09, F20-F54, F69 and F80-F99.

A8.2 Alcohol and drug: all episodes with a principal diagnosis of F10-F19 and F55.

A8.3 Nursing home type: all episodes for admitted patients staying 35 days or more for whom an acute care certificate has not been provided at the time of discharge.

A8.4 Rehabilitation: all episodes for admitted patients being admitted to designated rehabilitation units within an establishment.

A8.5 Intellectual handicap and developmental disability: all episodes with a principal diagnosis of F70-F79.

A8.6 Dental: all episodes with a principal diagnosis of K00-K08.

A8.7 Non-medical and social support: all episodes with a principal diagnosis of Z55-Z65, Z73-Z76 and Z02.

A8.8 Dialysis: all episodes with a principal diagnosis of Z49. Some variation may be required due to differences in State coding practices, for example, Z49.2 or the relevant procedure.

A8.9 Endoscopy and related diagnostic procedures: all episodes, regardless of principal diagnosis, with a ICD-10-AM principal procedure of:

- cystoscopy (36812-00 36860-00 36860-01 36836-00 36821-0037215-00 36806-00 36821-02 36818-00 36818-01 36812-01),

- gastroscopy (30473-00 30473-01 30478-00 3047801 30478-02 30478-03 30478-04),

Type of admitted patient care for overnight patients (continued)

Guide for use (cont'd): - oesophagoscopy (30473-03 30473-04 41822-00 30478-11 41825-0030478-10 30478-13 41816-00 41822-00 41825-00 41816-00),

- duodenoscopy (30473-00 30473-01 32095-00 30569-00 30478-0430478-00 30468-00),

- colonoscopy (32090-00 32090-01 90315-00 32093-00 32084-00 32084-01 32087-00 30375-23),

- sigmoidoscopy (32084-00 32084-01 32087-00 32075-00 32075-01 32078-00 32081-00 32072-01 30375-23),

- bronchoscopy (41889-00 41892-00 41892-01 41901-00 41895-00), and laryngoscopy (41849-00 41855-00 41867-00 41864-00 41858-00 41861-00 41852-00 41846-00 41764-03).

A8.10 Perinatal: all episodes with a principal diagnosis of P00-P96 with age less than 29 days. Multiple births are to be included.

A8.11 Medical/surgical/obstetrics: balance of episodes.

Note: For Public Psychiatric and Drug and Alcohol hospitals there is no requirement for the information by categories other than A8.1, A8.2 and A8.11.

New South Wales, Australian Capital Territory, Victoria and the Northern Territory implemented ICD-10-AM from 1 July 1998. Other States will implement ICD-10-AM from 1 July 1999.

Verification rules:

Collection methods:

Related data: supersedes previous data element Type of admitted patient care for overnight patients – ICD-9-CM 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 minimum data sets:

Comments:

Type of admitted patient care for same day patients

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000232 *Version number:* 3

Data element type: DERIVED DATA ELEMENT

Definition: The number of admitted patients separated on the day of admission totalled for specified programs within an institution.

Context: Institutional health care: this variable is required to describe adequately which broad programs of health care are provided in the establishment. Although this classificatory variable can be derived from the person-level data, a detailed description of the desired categories has been included in the National Health Data Dictionary to facilitate the routine production of a set of descriptive statistics for each establishment.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 7 *Representational layout:* NNNNNNNN

Data domain: Count the number of separations for each of the following categories.

Guide for use: A8.1 Mental health: all episodes with principal diagnosis of F00-F09, F20-F54, F69 and F80-F99.

A8.2 Alcohol and drug: all episodes with a principal diagnosis of F10-F19 and F55.

A8.3 Nursing home type: all episodes for admitted patients staying 35 days or more for whom an acute care certificate has not been provided at the time of discharge.

A8.4 Rehabilitation: all episodes for admitted patients being admitted to designated rehabilitation units within an establishment.

A8.5 Intellectual handicap and developmental disability: all episodes with a principal diagnosis of F70-F79.

A8.6 Dental: all episodes with a principal diagnosis of K00-K08.

A8.7 Non-medical and social support: all episodes with a principal diagnosis of Z55-Z65, Z73-Z76 and Z02.

A8.8 Dialysis: all episodes with a principal diagnosis of Z49. Some variation may be required due to differences in State coding practices, for example, Z49.2 or the relevant procedure.

A8.9 Endoscopy and related diagnostic procedures: all episodes, regardless of principal diagnosis, with a ICD-10-AM principal procedure of:

- cystoscopy (36812-00 36860-00 36860-01 36836-00 36821-0037215-00 36806-00 36821-02 36818-00 36818-01 36812-01),

- gastroscopy (30473-00 30473-01 30478-00 3047801 30478-02 30478-03 30478-04),

Type of admitted patient care for same day patients (continued)

Guide for use (cont'd):

- oesophagoscopy (30473-03 30473-04 41822-00 30478-11 41825-0030478-10 30478-13 41816-00 41822-00 41825-00 41816-00),
- duodenoscopy (30473-00 30473-01 32095-00 30569-00 30478-0430478-00 30468-00),
- colonoscopy (32090-00 32090-01 90315-00 32093-00 32084-00 32084-01 32087-00 30375-23),
- sigmoidoscopy (32084-00 32084-01 32087-00 32075-00 32075-01 32078-00 32081-00 32072-01 30375-23),
- bronchoscopy (41889-00 41892-00 41892-01 41901-00 41895-00), and laryngoscopy (41849-00 41855-00 41867-00 41864-00 41858-00 41861-00 41852-00 41846-00 41764-03).

A8.10 Perinatal: all episodes with a principal diagnosis of P00-P96 with age less than 29 days. Multiple births are to be included.

A8.11 Medical/surgical/obstetrics: balance of episodes.

Note: For Public Psychiatric and Drug and Alcohol hospitals there is no requirement for the information by categories other than A8.1, A8.2 and A8.11.

New South Wales, Australian Capital Territory, Victoria and the Northern Territory implemented ICD-10-AM from 1 July 1998. Other States will implement ICD-10-AM from 1 July 1999.

Verification rules:

Collection methods:

Related data: supersedes previous data element Type of admitted patient care for same day patients – ICD-9-CM 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 minimum data sets:

Comments:

Type of admitted patient care for short stay patients

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000389 *Version number:* 3

Data element type: DERIVED DATA ELEMENT

Definition: The number of admitted patients separated following a length of stay of less than 35 days totalled for specified programs within an institution.

Context: Institutional health care: this variable is required to describe adequately which broad programs of health care are provided in the establishment. Although this classificatory variable can be derived from the person-level data, a detailed description of the desired categories has been included in the National Health Data Dictionary to facilitate the routine production of a set of descriptive statistics for each establishment.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 7 *Representational layout:* NNNNNNN

Data domain: Count the number of separations for each of the following categories:

Guide for use: A8.1 Mental health: all episodes with principal diagnosis of F00-F09, F20-F54, F56-F69 and F80-F99.

A8.2 Alcohol and drug: all episodes with a principal diagnosis of F10-F19 and F55.

A8.11 Medical/surgical/obstetrics: balance of episodes.

New South Wales, Australian Capital Territory, Victoria and the Northern Territory implemented ICD-10-AM from 1 July 1998. Other States will implement ICD-10-AM from 1 July 1999.

Verification rules:

Collection methods: This data element is collected for public psychiatric and alcohol and drug hospitals only.

Related data: supersedes previous data element Type of admitted patient care for short stay patients – ICD-9-CM 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 minimum data sets:

Comments:

Type of non-admitted patient care

Admin. status: CURRENT 1/07/94

Identifying and definitional attributes

Knowledgebase ID: 000231 *Version number:* 1

Data element type: DERIVED DATA ELEMENT

Definition: This data element concept identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

Context: Required to describe the broad types of services provided to non-admitted patients, community patients and outreach clients.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 7 *Representational layout:* NNNNNNN

Data domain: Count number of non-admitted patient occasions of service.

Guide for use: Categories are as follows (definitions of each are given below):

Emergency department and emergency services

A9.1 emergency services

Outpatient services

A9.2 dialysis

A9.3 pathology

A9.4 radiology and organ imaging

A9.5 endoscopy and related procedures

A9.6 other medical/surgical/diagnostic

A9.7 mental health

A9.8 drug and alcohol

A9.9 dental

A9.10 pharmacy

A9.11 allied health services

Other non-admitted services

A9.12 community health services

A9.13 district nursing services

A9.14 other outreach services

Definitions:

A9.1 Emergency services: Services to patients who are not admitted and who receive treatment that was either unplanned or carried out in designated emergency departments within a hospital. Unplanned patients are patients who have not been booked into the hospital before receiving treatment. In general it would be expected that most patients would receive surgical or medical treatment. However, where patients receive other types of treatment that are provided in emergency departments these are to be included. The

Type of non-admitted patient care (*continued*)

Guide for use (cont'd): exceptions are for dialysis and endoscopy and related procedures which have been recommended for separate counting.

A9.2 Dialysis: This represents all non-admitted patients receiving dialysis within the establishment. Where patients receive treatment in a ward or clinic classified elsewhere (for example, an emergency department), those patients are to be counted as dialysis patients and to be excluded from the other category. All forms of dialysis which are undertaken as a treatment necessary for renal failure are to be included.

A9.3 Pathology: This includes all occasions of service to non-admitted patients from designated pathology laboratories. Occasions of service to all patients from other establishments should be counted separately.

A9.4 Radiology and organ imaging: This includes all occasions of service to non-admitted patients undertaken in radiology (X-ray) departments as well as in specialised organ imaging clinics carrying out ultrasound, computerised tomography (CT) and magnetic resonance imaging.

A9.5 Endoscopy and related procedures: This should include all occasions of service to non-admitted patients for endoscopy including:

- cystoscopy
- gastroscopy
- oesophagoscopy
- duodenoscopy
- colonoscopy
- bronchoscopy
- laryngoscopy

Where one of these procedures is carried out in a ward or clinic classified elsewhere, for example in the emergency department, the occasion is to be included under endoscopy and related procedures, and to be excluded from the other category. Care must be taken to ensure procedures or admitted patients are excluded from this category.

A9.6 Other medical / surgical / diagnostic: Any occasion of service to a non-admitted patient given at a designated unit primarily responsible for the provision of medical/surgical or diagnostic services which has not been covered in the above. These include ECG, obstetrics, nuclear medicine, general medicine, general surgery, fertility and so on.

A9.7 Mental health: All occasions of service to non-admitted patients attending designated psychiatric or mental health units within hospitals.

A9.8 Alcohol and drug: All occasions of service to non-admitted patients attending designated drug and alcohol units within hospitals.

A9.9 Dental: All occasions of service to non-admitted patients attending designated dental units within hospitals.

A9.10 Pharmacy: This item includes all occasions of service to non-admitted patients from pharmacy departments. Those drugs dispensed/administered in other departments such as the emergency department, or outpatient departments, are to be counted by the respective departments.

Type of non-admitted patient care (*continued*)

Guide for use (cont'd): A9.11 Allied health services: This includes all occasions of service to non-admitted patients where services are provided at units/clinics providing treatment/counselling to patients. These include units primarily concerned with physiotherapy, speech therapy, family planning, dietary advice, optometry, occupational therapy and so on.

A9.12 Community health services: Occasions of service to non-admitted patients provided by designated community health units within the establishment. Community health units include:

- baby clinics
- immunisation units
- aged care assessment teams
- other

A9.13 District nursing service: Occasions of service to non-admitted patients which:

- are for medical/surgical/psychiatric care
- are provided by a nurse, paramedic or medical officer
- involve travel by the service provider*
- are not provided by staff from a unit classified in the community health category above.

A9.14 Other outreach services: Occasions of service to non-admitted patients which:

- involve travel by the service provider*
- are not classified in allied health or community health services above

*Travel does not include movement within an establishment, movement between sites in a multi-campus establishment or between establishments. Such cases should be classified under the appropriate non-admitted patient category.

It is intended that these activities should represent non-medical/surgical/psychiatric services. Activities such as home cleaning, meals on wheels, home maintenance and so on should be included.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted, should be identified as a subset of the total occasions of service.

Verification rules:

Collection methods: The list of categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide

Type of non-admitted patient care (*continued*)

Collection methods (cont'd): services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Related data:

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

Institutional health care from 1/07/89 to

Comments: Outreach/community care is care delivered by hospital employees to the patient in the home, place of work or other non-hospital site. The distinction between non-admitted patient care and outreach care is that for non-admitted patient care the patients travel to the health care providers while for outreach care the health care providers travel to the patients.

This distinction creates difficulties for community health centres. These centres are to be included in the national minimum data set where they are funded as sections within establishments that fall within the scope of the National Health Data Dictionary.

For example, baby clinics, immunisation groups or aged care assessment teams, which are funded through acute hospitals, may provide care to some clients within the hospital grounds or externally. It is intended that all community health activity be measured under community health regardless of where the services are provided.

Type of non-admitted patient care (nursing homes and hostels)

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000234 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Outpatients are patients who receive non-admitted care. Non-admitted care is care provided to a patient who is not formally admitted but receives direct care from a designated clinic within the nursing home/hostel

For outreach/community patients, care is delivered by nursing home/hostel employees to the patient in the home, place of work or other non-establishment site.

Context: Required to adequately describe the services provided to non-admitted patients.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 3 *Representational layout:* NNN

Data domain: A11.1 Occasions of service to outpatients

A11.2 Occasions of service to outreach / community patients

Guide for use:

Verification rules:

Collection methods:

Related data:

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

Comments: Apart from acute hospitals, establishments generally provide a much more limited range of services for non-admitted patients and outreach/community patients/clients. Therefore disaggregation by type of episode is not as necessary as in acute hospitals.

This data element will be reviewed during 1999.

Type of non-admitted patient care (public psychiatric, alcohol and drug)

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000233 *Version number:* 1

Data element type: DERIVED DATA ELEMENT

Definition: Emergency and outpatients are patients who receive non-admitted care. Non-admitted care is care provided to a patient who receives direct care within the emergency department or other designated clinics within the hospital and who is not formally admitted at the time when the care is provided. A patient who first contacts the hospital and receives non-admitted care, for example through the emergency department, and is subsequently admitted should have both components of care enumerated separately.

For outreach/community patients, care delivered by hospital employees to the patient in the home, place of work or other non-hospital site.

A group is defined as two or more patients receiving a service together, where all individuals are not members of the same family. Family services are to be treated as occasions of service to an individual.

Context: Required to adequately describe the services provided to non-admitted patients in public psychiatric hospitals and alcohol and drug hospitals.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 7 *Representational layout:* NNNNNNN

Data domain: Count occasions of service for the following categories:

Guide for use: Emergency and outpatient occasions of service

1 Individual patients

2 Groups

Outreach / community occasions of service

3 Individual patients

4 Groups

Verification rules:

Collection methods: The working party discussed the need to distinguish different types of psychiatric outpatient services in psychiatric hospitals. South Australia outlined its categories of psychiatric outpatients:

- day patients (not admitted but are day program patients);

- outpatients (typically 20 minutes consultation); community/outreach (outreach services provided by staff off the hospital site, including community health service provided off-site and domiciliary care); and casualty patients (designated casualty area, mirroring usual hospital set up).

These categories also applied to mental health clinics in South Australia. The working party agreed that the South Australian categories were useful, but

Type of non-admitted patient care (public psychiatric, alcohol and drug) (*continued*)

Collection methods (cont'd):

that outpatient and casualty categories should be collapsed as there was a boundary problem between these two categories.

The working party initially recommended the following categories for activity data for outpatient services at establishment level:

- day program patients
- emergency and other outpatients
- outreach/community

The first two of the above categories cover all outpatients treated on the hospital site, the latter covers outreach services provided by the staff off the hospital site. It includes community health services provided by hospital staff off-site.

The working party then discussed the unit of counting for activity data. The Psychiatric Working Party reviewed the recommendation of the In-patient/Non-in-patient Working Party that occasions of service should be the appropriate unit of counting. The following points were raised:

- The method of counting the number of group sessions in a psychiatric setting was difficult because a day patient is always a group patient. Also, groups would have a mixture of in-patients and outpatients.
- Counting occasions of service for a day patient was difficult because a patient could have up to eight treatment encounters in one day.
- From a client perspective, groups should be ignored and information should be collected on every individual.
- Queensland counted the number of days on which contact is made, irrespective of intensity of service.
- It was suggested that occasions of service (or individuals) be counted but that the information should be divided into one-on-one sessions or group sessions, for resource implications.
- Some members thought that, in terms of resources, groups of staff and type of provider were more important than number of clients.
- Victoria proposed a bare bones approach, and recommended that only occasions of service be counted. All the other points raised were important dimensions, but Victoria felt that to do justice to them, it would be necessary to include community services, phone consultations and so on, which was not feasible at this stage.
- The Psychiatric Working Party foreshadowed the need to categorise outpatients further into child, adult and other. It was generally agreed that while this aspect would be worthwhile flagging in a policy statement, it was not necessary to consider it at this stage.
- The Psychiatric Working Party also agreed that occasions of service was the preferred counting unit for non-admitted patient activity data. It was noted that the acute sector had opted for this unit.
- The Psychiatric Working Party recommended that a family was to be counted as one occasion of service (individual session) not as a group, and that a family

Type of non-admitted patient care (public psychiatric, alcohol and drug) (*continued*)

Collection methods (cont'd): unit was to be determined as a group of people which identified themselves as such.

The Psychiatric Working Party agreed that the unit of counting of services should be as follows:

- day program attendances
- other outpatient occasions of service
- outreach occasions of service.

Day program patients should be counted as number of attendances to a day program (patient days). Day program patient occasions of service with other staff should be counted separately as other outpatient occasions of service.

Related data:

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

Institutional health care from 1/07/89 to

Comments: In general, establishments other than acute hospitals provide a much more limited range of services for non-admitted patients and outreach/community patients/clients. Therefore, disaggregation by type of non-admitted patient care is not relevant to psychiatric and alcohol/drug hospitals.

Patients in residence at year end

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000208 *Version number:* 1

Data element type: DERIVED DATA ELEMENT

Definition: A headcount of all formally admitted patients/clients in residence in long-stay facilities (public psychiatric hospitals, alcohol and drug hospitals, nursing homes) at midnight, to be done on 30 June.

Context: The number of separations and bed days for individual long-stay establishments is often a poor indication of the services provided. This is because of the relatively small number of separations in a given institution. Experience has shown that the number of patients/clients in residence can often give a more reliable picture of the levels of services being provided.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 4 *Representational layout:* NNNN

Data domain: Number of admitted patients / clients in residence

Guide for use:

Verification rules:

Collection methods: For public psychiatric hospitals and alcohol and drug hospitals, all States have either an annual census or admission tracking that would enable a statistical census. The Commonwealth Department of Health and Family Service is able to carry out a statistical census from its nursing homes databases. No system is presently in place for hostels.

A headcount snapshot could be achieved either by census or by the admission/discharge derivation approach.

There are difficulties with the snapshot in view of both seasonal and day of the week fluctuations. Most of the traffic occurs in a small number of beds.

Any headcount should avoid the problems associated with using 31 December or 1 January. The end of the normal financial year is probably more sensible (the Wednesday before the end of the financial year was suggested, but probably not necessary). This should be qualified by indicating that the data does not form a time series in its own right.

Related data:

Administrative attributes

Source document:

Source organisation: Morbidity Working Party

National minimum data sets:

Comments:

Separations

Admin. status: CURRENT 1/07/94

Identifying and definitional attributes

Knowledgebase ID: 000205 *Version number:* 2

Data element type: DERIVED DATA ELEMENT

Definition: The total number of separations occurring during the reference period. This includes both formal and statistical separations.

Context: Admitted patient care: needed as the basic count of the number of separations from care for an establishment.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 6 *Representational layout:* NNNNNN

Data domain: A number, representing the number of completed episodes of care

Guide for use: The sum of the number of separations where the Discharge date has a value:
>= the beginning of the reference period (typically a financial year); and
<= the end of the reference period.
This sum may be calculated at:
- individual establishment level; or
- system (ie. State/Territory) level ie. the sum of the number of establishments.

Verification rules:

Collection methods: For the national minimum data set – institutional health care the reference period for data collection is a financial year ie. 1 July to 30 June inclusive.

Related data: relates to the data element concept Separation, version 1
supersedes previous derived data element Separations, version 1
is derived from Separation date, version 5

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Community mental health care from 1/07/98 to

Comments:

Emergency Department waiting time to admission

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000397 *Version number:* 1

Data element type: DERIVED DATA ELEMENT

Definition: The time elapsed for each patient from presentation to the Emergency Department to admission to hospital.

Context: Emergency care: this is a critical waiting times data item. This item is used to examine the length of waiting time, for performance indicators and benchmarking. Information based on this data item will have many uses including to assist in the planning and management of hospitals and in health care research.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 4 *Max.* 4 *Representational layout:* HHMM

Data domain: Count in numbers of hours and minutes

Guide for use: Calculated from admission date and time minus date and time patient presents for those Emergency Department patients who are admitted.

Verification rules:

Collection methods: To be collected on patients presenting to Emergency Department for unplanned care in public hospitals with Emergency Department and private hospitals providing contracted services for the public sector.

Related data: is calculated using Admission date, version 4
relates to the data element concept Patient presentation at Emergency Department, version 1
is calculated using Date patient presents, version 1
is calculated using Time patient presents, version 1
is calculated using Admission time, version 1
is calculated using Departure status, version 1

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Comments:

Emergency Department waiting time to service delivery

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000347 *Version number:* 1

Data element type: DERIVED DATA ELEMENT

Definition: The time elapsed for each patient from presentation to the Emergency Department to commencement of service by a treating medical officer or nurse.

Context: Emergency care: this is a critical waiting times data item. This item is used to examine the length of waiting time, for performance indicators and benchmarking. Information based on this data item will have many uses including to assist management of Emergency Departments, the planning and management of hospitals and in health care related research.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 4 *Max.* 4 *Representational layout:* HHMM

Data domain: Count in numbers of hours and minutes

Guide for use: Calculated from date and time of service event minus date and time patient presents. Although triage category 1 is measured in seconds, it is recognised that the data will not be collected with this precision.

Verification rules:

Collection methods: To be collected on patients presenting to Emergency Department for unplanned care in public hospitals with Emergency Department and private hospitals providing contracted services for the public sector.

Related data: is used in the calculation of Triage category (trial), version 1
is calculated using Date patient presents, version 1
is calculated using Time patient presents, version 1
is calculated using Date of service event, version 1
is calculated using Time of service event, version 1

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Emergency Department waiting times from 1/07/99 to

Comments: It is recognised that at times of extreme urgency or multiple synchronous presentations, or if no medical officer is on duty in the Emergency Department, this service may be provided by a nurse.

This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department waiting times National Minimum Data Set.

Occasions of service

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000209 *Version number:* 1

Data element type: DERIVED DATA ELEMENT

Definition: The number of occasions of examination, consultation, treatment or other service provided to a patient in each functional unit of a health service establishment. Each diagnostic test or simultaneous set of related diagnostic tests for the one patient referred to a hospital pathology department consists of one occasion of service.

Context: Institutional health care: occasions of service are required as a measure of non-admitted patient service provision.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 7 *Representational layout:* NNNNNNN

Data domain: Number of occasions of service

Guide for use:

Verification rules:

Collection methods: The proposed definition does not distinguish case complexity for non-admitted patients. For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average Diagnosis Related Group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition. For admitted patients the concept of a separation is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Related data:

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

Institutional health care from 1/07/89 to

Comments: Some overlap with the data elements Number of service contact dates, Service contact date and Service contact (concept) is acknowledged by the National Health Data Committee and is subject to further work during 1999.

Length of stay

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000119 *Version number:* 1

Data element type: DERIVED DATA ELEMENT

Definition: Hospital

The length of stay of a patient is calculated by subtracting the date the patient is admitted from the date of separation. All leave days, including the day the patient went on leave, are excluded from the calculation. A same-day patient should be allocated a length of stay of one day.

Length of stay – antenatal

To calculate antenatal length of stay, subtract the date the mother is admitted from the date of delivery. All leave days, including the day the mother went on leave, are excluded from the calculation.

Length of stay – postnatal

To calculate postnatal length of stay, subtract the date the mother is separated from the date of delivery. All leave days, including the day the mother went on leave, are excluded from the calculation.

Context: Institutional health care

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 3 *Representational layout:* NNN

Data domain: Count number of days

Guide for use:

Verification rules:

Collection methods:

Related data: is calculated using Admission date, version 4

is derived from Number of leave periods, version 3

is calculated using Separation date, version 5

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Comments: This data element was previously included in the Terminology section of the dictionary.

While a similar concept of duration of service applies in other institutional care settings, and similar measurement principles apply, different terminology is used in those other settings to describe the duration of care.

Number of acute (qualified)/unqualified days for newborns

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000346 *Version number:* 1

Data element type: DERIVED DATA ELEMENT

Definition: The number of acute (qualified) and unqualified newborn days occurring within a newborn episode of care.

Context:

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 3 *Representational layout:* NNN

Data domain: Count number of days

Guide for use: The rules for calculating the number of acute (qualified) and unqualified newborn days are outlined below:

- the number of acute (qualified) and unqualified days are calculated from the date of admission, date of separation and any date(s) of change to qualification status.
- the date of admission is counted as a day against the initial qualification status.
- the day on which a change in qualification status occurs is counted against the new qualification status.
- if more than one change of qualification status occurs on a single day, the day is counted against the final qualification status for that day.
- the date of separation is not counted as either an acute (qualified) or unqualified day.
- normal rules which apply to calculation of patient days apply, e.g. same day, leave.
- the newborn's length of stay is equal to the sum of the acute (qualified) and unqualified days.

Verification rules:

Collection methods:

Related data: is used in the calculation of Length of stay, version 1
is used in the calculation of Patient days, version 2
is used in conjunction with Date of change to qualification status, version 1

Administrative attributes

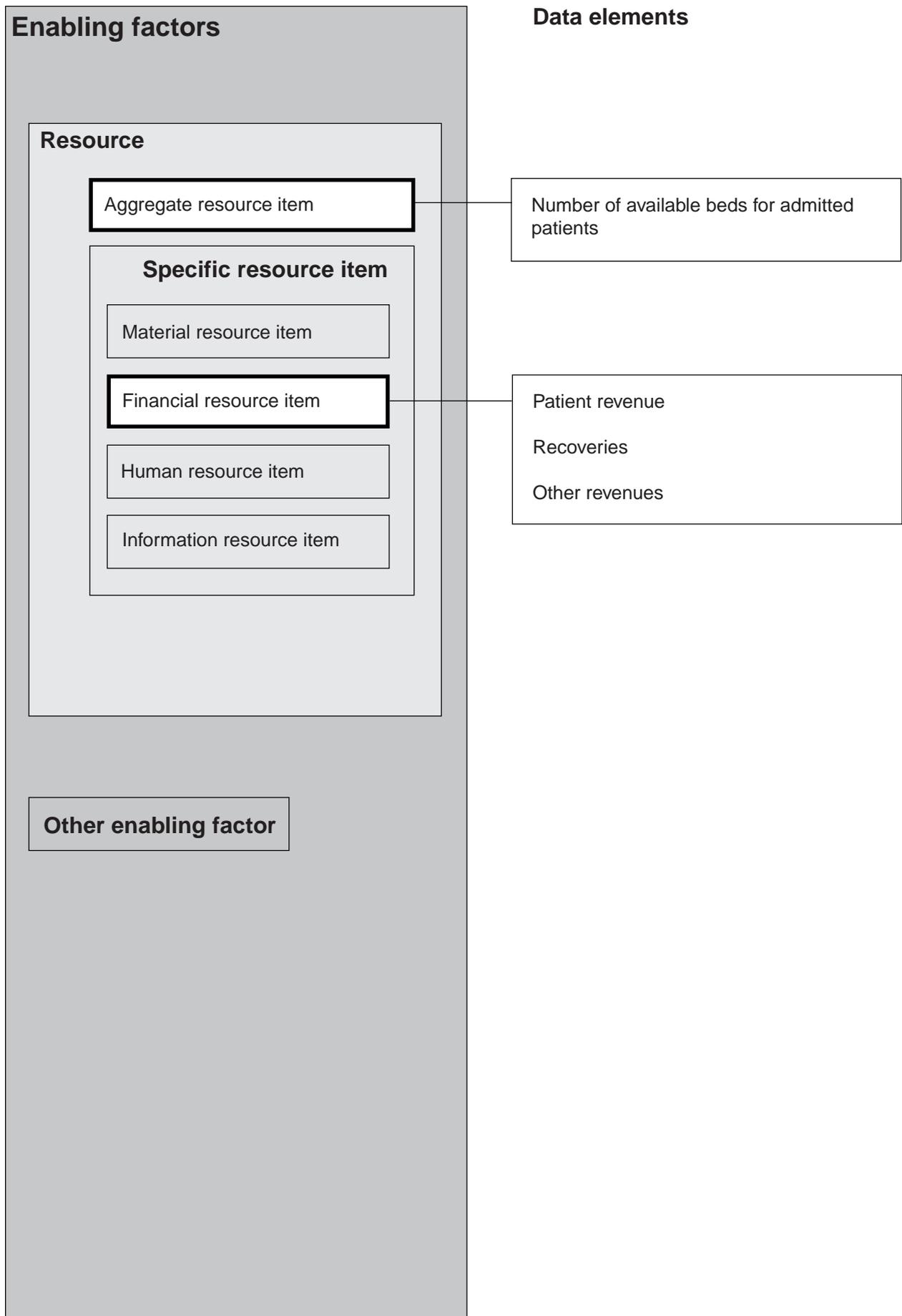
Source document:

Source organisation:

National minimum data sets:

Comments:

National Health Information Model entities



Number of available beds for admitted patients

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000255 *Version number:* 2

Data element type: DATA ELEMENT

Definition: An available bed is a bed which is immediately available to be used by an admitted patient or resident if required. A bed is immediately available for use if it is located in a suitable place for care with nursing and auxiliary staff available within a reasonable period.

Inclusions: both occupied and unoccupied beds are included. For nursing homes, the number of approved beds includes beds approved for respite care.

Exclusions: surgical tables, recovery trolleys, delivery beds, cots for normal neonates, emergency stretchers / beds not normally authorised or funded and beds designated for same-day non-admitted patient care are excluded. Beds in wards which were closed for any reason (except weekend closures for beds / wards staffed and available on weekdays only) are also excluded.

Context: Institutional health care admitted patients: necessary to provide an indicator of the availability and type of service for an establishment.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 4 *Representational layout:* NNNN

Data domain: Average available beds, rounded to the nearest whole number

Guide for use: The average bed is to be calculated from monthly figures.

Verification rules:

Collection methods:

Related data: relates to the data element concept Admitted patient, version 1
supersedes previous data element Number of available beds for admitted patients, version 1

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Community mental health care from 1/07/98 to

Comments: This National Health Data Dictionary entry was amended during 1996-97. Until then, both average and end of year counts of available beds were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate characterisation of establishments and comparisons.

Patient revenue

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000296 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Patient revenue comprises all revenue received by, and due to, an establishment in respect of individual patient liability for accommodation and other establishment charges. All patient revenue is to be grouped together regardless of source of payment (Commonwealth, health fund, insurance company, direct from patient) or status of patient (whether in-patient or non-in-patient, private or compensable). Gross revenue should be reported.

Note: The Commonwealth contribution in respect of nursing home patients should be included under patient revenue.

Context: Health expenditure: patient revenue is a significant source of income for most establishments. For some establishments (principally the private sector) it is the major source of income. Patient revenue data is important for any health financing analyses or studies at the national level.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 9 *Representational layout:* \$\$\$,\$\$\$,\$\$\$

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data: relates to the data element Establishment type, version 1

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

Institutional health care from 1/07/89 to

Comments: The Resources Working Party considered a split of patient revenue into various categories including an in-patient/non-in-patient split and a private/compensable/ineligible split but decided against this level of detail. In part, this reflected sensitivities to too detailed a disclosure of sources of revenue and also a feeling that total patient revenue was adequate for analysis at a national level. However, for nursing home patient revenue, the Commonwealth Department of Community Services and Health nursing home experts said they would like

Patient revenue (*continued*)

Comments (cont'd): to see a limited split up of patient revenue perhaps along the following lines:

Nursing homes

- Commonwealth benefit

- residents payment

Hostels

- Commonwealth benefit

- resident recurrent funding

- resident capital funding

Recoveries

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000295 *Version number:* 1

Data element type: DATA ELEMENT

Definition: All revenue received that is in the nature of a recovery of expenditure incurred. This would include:

- income received from the provision of meals and accommodation to members of staff of the hospital (assuming it is possible to separate this from income from the provision of meals and accommodation to visitors;

- income received from the use of hospital facilities by salaried medical officers exercising their rights of private practice and by private practitioners treating private patients in hospital; and

- other recoveries such as those relating to inter-hospital services where the revenue relates to a range of different costs and cannot be clearly offset against any particular cost.

Generally, gross revenues should be reported but, where inter-hospital payments for transfers of goods and services are made, offsetting practices are acceptable to avoid double counting. Where a range of inter-hospital transfers of goods and services is involved and it is not possible to allocate the offsetting revenue against particular expenditure categories, then it is acceptable to bring that revenue in through recoveries.

Context: Health expenditure: recoveries represent a significant source of income for many establishments and, as well as assisting in completing the picture in any health financing studies or analysis at the national level, are relevant in relation to the determination of net costs and output costs.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 9 *Representational layout:* \$\$\$\$\$\$

Data domain:

Guide for use: This data element relates to all revenue received by establishments except for general revenue payments received from State or Territory governments.

Verification rules:

Collection methods:

Related data: relates to the data element Establishment type, version 1

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

Recoveries (*continued*)

National minimum data sets:

Institutional health care from 1/07/89 to

Comments:

The Resources Working Party had considered splitting recoveries into staff meals and accommodation, and use of hospital facilities (private practice) and other recoveries.

Some States had felt that use of facilities was too sensitive as a separate identifiable item in a national minimum data set. Additionally, it was considered that total recoveries was an adequate category for health financing analysis purposes at the national level.

Other revenues

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000323 *Version number:* 1

Data element type: DATA ELEMENT

Definition: All other revenue received by the establishment that is not included under patient revenue or recoveries (but not including revenue payments received from State or Territory governments). This would include revenue such as investment income from temporarily surplus funds and income from charities, bequests and accommodation provided to visitors.

See text relating to offsetting practices. Gross revenue should be reported (except in relation to payments for inter-hospital transfers of goods and services).

Context: Health services: in aggregate, other revenues as defined above constitute a significant source of income for many establishments and are necessary to complete the revenue picture for health financing studies or analyses at the national level.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 1 *Max.* 9 *Representational layout:* \$\$\$,\$\$\$,\$\$\$

Data domain:

Guide for use:

Verification rules: Australian dollars. Rounded to nearest whole dollar.

Collection methods:

Related data: relates to the data element Establishment type, version 1

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Comments:

Appendix A: The National Health Data Committee membership

The National Health Data Committee membership as at February 1999 was:

Member	Organisation	Telephone	Facsimile	E-mail
Mr Michael Bassingthwaighe	(Private health insurance industry representative) Lysaght's Hospital and Medical Club PO Box 77 PORT KEMBLA NSW 2505	(02) 4224 4301	(02) 4224 4300	michaeljbass@ozemail.com.au
Mr Peter Callanan	Director Health Insurance Services Department of Health and Aged Care GPO Box 9848 CANBERRA ACT 2601	(02) 6289 8530	(02) 6289 7900	peter.callanan@health.gov.au
Mr Joe Christensen	Head Information Development Unit Australian Institute of Health and Welfare GPO Box 570 CANBERRA ACT 2601	(02) 6244 1148	(02) 6244 1255	joe.christensen@aihw.gov.au
Ms Sue Cornes	Manager Data Collection Unit Epidemiology and Health Information Branch Queensland Department of Health GPO Box 48 BRISBANE QLD 4001	(07) 3234 0889	(07) 3234 1529	suzanne_cornes@health.qld.gov.au
Mr Peter Crowe	Assistant Director Health Statistics Section Australian Bureau of Statistics PO Box 10 BELCONNEN ACT 2616	(02) 6252 6967	(02) 6252 8007	peter.crowe@abs.gov.au
Ms Julie Gardner	Manager Data Management Unit South Australian Department of Human Services PO Box 65, Rundle Mall ADELAIDE SA 5001	(08) 8226 7328	(08) 8226 7341	julie.gardner@health.sa.gov.au
Ms Sam Green	Assistant Manager Information Planning and Strategies Unit Health Information Centre Health Department of Western Australia PO Box 8172, Stirling Street PERTH WA 6849	(08) 9222 2410	(08) 9222 2436	sam.green@health.wa.gov.au
Ms Jenny Hargreaves	Head Patient Morbidity and Services Unit Australian Institute of Health and Welfare GPO Box 570 CANBERRA ACT 2601	(02) 6244 1121	(02) 6244 1255	jenny.hargreaves@aihw.gov.au
Mr David Hunter	Director Classifications and Data Standards Australian Bureau of Statistics PO Box 10 BELCONNEN ACT 2616	(02) 6252 6300	(02) 6252 5281	david.hunter@abs.gov.au
Mr Kevin Johnston	Acting Associate Director Health Informatics New South Wales Department of Health Locked Mail Bag 961 NORTH SYDNEY NSW 2060	(02) 9391 9918	(02) 9391 9015	kjohn@doh.health.nsw.gov.au
Ms Amanda Lanagan	Information Management Unit Territory Health Services PO Box 40596 CASUARINA NT 0811	(08) 8999 2520	(08) 8999 2618	Amanda.lanagan@health.nt.gov.au
Mr Mark Gill	Acute Health Division Victorian Department of Human Services GPO Box 4057 MELBOURNE VIC 3001	(03) 9616 7456	(03) 9616 7629	mark.gill@dhs.vic.gov.au

(Continued)

Member	Organisation	Telephone	Facsimile	E-mail
Ms Jo Murray	Assistant Secretary Classification and Payments Branch Department of Health and Aged Care GPO Box 9848 CANBERRA ACT 2601	(02) 6289 7493	(02) 6289 7630	jo.murray@health.gov.au
Mr Steve Quilliam	IT Services Manager Australian Private Hospitals Association PO Box 346 CURTIN ACT 2605	(02) 6285 2716	(02) 6285 2243	steve.quilliam@apha.org.au
Mr David O'Brien	Data Analyst Hospital and Ambulance Services Tasmanian Department of Health and Human Services GPO Box 125B HOBART TAS 7001	(03) 6233 6221	(03) 6233 2909	david.obrien@dchs.tas.gov.au
Mr Murray Rye	Assistant Director Private Hospital Arrangements Department of Veterans' Affairs PO Box 21 WODEN ACT 2606	(02) 6289 6017	(02) 6289 6787	murray.rye@dva.gov.au
Mr Geoff Sims (Chair)	Head Health Division Australian Institute of Health and Welfare GPO Box 570 CANBERRA ACT 2601	(02) 6244 1168	(02) 6244 1166	geoff.sims@aihw.gov.au
Mr Mohan Singh	Contract Monitoring Department of Health and Community Care GPO Box 825 CANBERRA ACT 2601	(02) 6205 0873	(02) 6205 0842	mohan_singh@dpa.act.gov.au
Ms Sue Walker	Director School of Public Health National Centre for Classification in Health Queensland University of Technology Locked Bag No. 2 RED HILL QLD 4059	(07) 3864 5873	(07) 3864 5515	s.walker@qut.edu.au

Appendix B: Format for data element definitions – ISO/IEC 11179-based standards

All data element definitions included in the *National Health Data Dictionary* are presented in a format based on ISO/IEC Standard 11179 *Specification and Standardization of Data Elements* – the international standard for defining data elements issued by the International Organization for Standardization and the International Electrotechnical Commission. Collectively, the format describes a set of attributes for data definitions. The set of attributes for data definitions used in the *National Health Data Dictionary* is described below.

Administrative status:	The operational status (e.g. CURRENT or SUPERSEDED) of the data element or data element concept and the date from which this status is effective. For example, in the Dictionary the latest revision of 'Area of usual residence', effective from 1 July 1997, has a CURRENT status, replacing the previous version of this data element, operational from 1 July 1995 until 30 June 1997, which now has a SUPERSEDED status. No SUPERSEDED data elements are included in this hard copy publication of the Dictionary. However, all data elements, including SUPERSEDED data elements, are included on the Knowledgebase.
Knowledgebase ID:	A six-digit number used to identify the data element on the Knowledgebase (previously known as the NHIK). In the Knowledgebase, this number is preceded by an acronym that identifies the registration authority for each data element. The National Health Information Management Group is the registration authority for all data elements included in the Dictionary. The combination of registration authority, Knowledgebase (or NHIK) ID and version number (see below) uniquely identifies each data element in the Knowledgebase.
Version number:	A version number for each data element, beginning with 1 for the initial version of the data element, and 2, 3 etc. for each subsequent revision. This meets the ISO/IEC Standard 11179 requirement for 'identification of a data element specification in a series of evolving data element specifications within a registration authority'. A new version number is allocated to a data element or data element concept when changes have been made to one or more of the following attributes of the definition: <ul style="list-style-type: none"> - name - definition - data domain.

Identifying and definitional attributes

Name:	A single or multi-word designation assigned to a data element. This appears in the heading for each unique data definition in the Dictionary.
Data element type:	A data element may be: <ol style="list-style-type: none"> a. A DATA ELEMENT CONCEPT – a concept that can be represented in the form of a data element, described independently of any particular representation. For example, hospital 'admission' is a process which does not have any particular representation of its own, except through data elements such as 'admission date', 'mode of admission', etc. b. A DATA ELEMENT – a unit of data for which the definition, identification, representation and permissible values are specified by means of a set of attributes. For example, a hospital 'admission date' is a unit of data for which the definition, identification, representation and permissible values are specified.

- c. A DERIVED DATA ELEMENT – a data element for which values are derived by calculation from the values of other data elements. For example, the data element ‘length of stay’, which is derived by calculating the number of days from ‘admission date’ to ‘separation date’ less any ‘total leave days’.
- d. A COMPOSITE DATA ELEMENT – a data element the values of which represent a grouping of the values of other data elements in a specified order. For example, the data element ‘establishment identifier’ is a grouping of the data elements ‘state identifier’, ‘establishment type’, ‘region’ and ‘establishment number’ in that order.

Definition:	A statement that expresses the essential nature of a data element and its differentiation from all other data elements.
Context:	A designation or description of the application environment or discipline in which a name is applied or from which it originates. For example, the context of ‘admission date’ is ‘admitted patients’, while the context of ‘capital expenditure – gross’ is ‘health expenditure’. For the dictionary this attribute may also include the justification for collecting the items and uses of the information.

Relational and representational attributes

Data type:	The type of symbol, character or other designation used to represent a data element. Examples include integer, numeric, alphanumeric, etc. For example, the data type for ‘intended place of birth’ is a numeric drawn from a domain or code set in which numeric characters such as ‘1=hospital, 4=home’ are used to denote a data domain value (see data domain below).
Representational form:	Name or description of the form of representation for the data element, such as ‘CODE’, ‘QUANTITATIVE VALUE’, and ‘DATE’. For example, the representational form for ‘country of birth’ is ‘CODE’ because the form of representation is individual numbers that each represent a different country.
Field size (minimum and maximum):	The minimum and maximum number, respectively, of storage units (of the corresponding data type) used to represent the data element value. For example, a data element value expressed in dollars may require a minimum field size of one character (1) up to a maximum field size of nine characters (999, 999, 999). Field size does not generally include characters used to mark logical separations of values, e.g. commas, hyphens or slashes.
Representational layout:	The layout of characters in data element values expressed by a character string representation. Examples include ‘DDMMYYYY’ for calendar dates, ‘N’ for one-digit numeric fields, and ‘\$\$\$,\$\$\$,\$\$\$’ for data elements about expenditure.
Data domain:	The set of representations of permissible instances of the data element, according to the representation form, layout, data type and maximum size specified in the corresponding attributes. The set can be specified by name (including an existing classification/code scheme such as ICD-10-AM), by reference to a source (such as the <i>ABS Directory of concepts and standards for social, labour and demographic statistics, 1995</i>), or by enumeration of the representation of the instances (for example, for ‘compensable status’, values are ‘1=compensable, 2=non-compensable’).
Guide for use (optional):	Additional comments or advice on the interpretation or application of the attribute ‘data domain’. (This attribute has no direct counterpart in the ISO/IEC Standard 11179 but has been included to assist in the clarification of issues relating to the classification of data elements.)
Verification rules (optional):	The rules and/or instructions applied for validating and/or verifying data elements occurring in actual communication and/or databases, in addition to the formal screening based on the requirements laid down in the basic attributes.

Collection methods (optional):	Comments and advice concerning the actual capture of data for the particular data element, including guidelines on the design of questions for use in collecting information, and the treatment of 'not stated' or non-response data. (This attribute is not specified in the ISO/IEC Standard 11179 but has been added to cover important issues about the actual collection of data.)
Related data (optional):	A reference between the data element or data element concept and any related data element or data element concept in the Dictionary, including the type of their relationship. Examples include 'has been superseded by the data element...', 'is calculated using the data element...', and 'supplements the data element...'.
Administrative attributes	
Source document (optional):	The document from which definitional or representational attributes originate.
Source organisation:	The organisation responsible for the source document and/or the development of the data definition (this attribute is not specified in the ISO/IEC Standard 11179 but has been added for completeness). The source organisation is not necessarily the organisation responsible for the ongoing development/maintenance of the data element definition.
National minimum data sets (optional):	The name of any national minimum data set established under the auspices of the National Health Information Agreement (NHIA) which includes the particular data element. The date of effect is also included.
Comments (optional):	Any additional explanatory remarks on the data element.

Appendix C: National Health Information Model entity definitions

ENTITY NAME	ENTITY DEFINITION
Accessibility factor	<p>An instance of a factor that influences, determines or affects access to services, providers and information.</p> <p>For example, privacy of records, location of persons and providers or distance from medical services.</p>
Accommodation characteristic	<p>The living arrangements of a PERSON.</p> <p>For example, the type of dwelling, age of dwelling, number of bedrooms, modification of dwelling to account for restricted movement etc.</p> <p>In the National Health Information Model, ACCOMMODATION CHARACTERISTIC relates to where a PERSON usually resides. If information is being collected about ACCOMMODATION CHARACTERISTICS at an instance in time – for example while a PERSON is in receipt of care, the data element will fall within the SETTING entity.</p>
Acute event	<p>An acute illness-related LIFE EVENT experienced by a PERSON.</p> <p>For example, the diagnosis of a disease.</p>
Address	<p>The address at which a PERSON, PARTY or ORGANISATION may be contacted/located or where an item may be located.</p> <p>ADDRESS has been modified from Version 1.0 of the National Health Information Model. It now encompasses all those elements of an address which were previously separated in Version 1.0 such as country, State/Territory, city, postcode and street or postal address, telephone, facsimile and electronic mail addresses.</p>
Advocacy event	<p>An EVENT associated with the act of communicating, defending and recommending a cause or position or acting as an agent.</p>
Advocate role	<p>A PERSON in their role as an advocate for another PARTY.</p>
Aggregate health and wellbeing	<p>A composite measure of the health and wellbeing of a PERSON. It generally involves measures/instruments that assess the multidimensional factors that contribute to health and wellbeing.</p> <p>For example, measures currently in use in Australia include SF-36 and SF-12 scores, quality of life measures, and health expectancies.</p>
Aggregate resource item	<p>An instance of aggregate or total RESOURCES.</p> <p>For example, total nursing staff or the total budget allocated to a program or organisation.</p> <p>While the National Health Information Model recognises the individual RESOURCE items (MATERIAL, FINANCIAL, HUMAN and INFORMATION RESOURCE ITEMS), it is the totals of these items that are most commonly used in RESOURCE management.</p>
Assessment event	<p>An EVENT associated with the gathering and analysis of information concerning a PARTY.</p> <p>For example, an assessment of home-based care requirements or a diagnosis.</p>
Attitude	<p>The ATTITUDEs of a PERSON towards health, health care and the health and welfare systems.</p>

ENTITY NAME	ENTITY DEFINITION
Availability factor	<p>An instance of a factor that influences, determines or affects the availability of services for a PERSON or group.</p> <p>For example, the availability of services such as employment assistance for a PERSON with a disability.</p>
Belief	The BELIEFs of a PERSON about health, health care and the health and welfare systems.
Benchmark	<p>A criterion against which something is measured.</p> <p>Compare with STANDARD.</p>
Birth event	<p>The EVENT of being born.</p> <p>It describes EVENTS which happen to both the baby and the mother during the birth, but does not include descriptions of the of the health of the baby or mother; these elements are mapped to subtypes of the STATE OF HEALTH AND WELLBEING entity.</p>
Built environment	<p>The BUILT ENVIRONMENT (or man-made environment) in which a PERSON or community lives.</p> <p>For example, quality of housing and access to appropriate sanitation systems.</p>
Business agreement	<p>An agreement or contract between parties which specifies the roles and responsibilities of each in relation to a health and welfare program.</p> <p>For example, purchaser-provider agreements, employment contracts, service contracts and other funding agreements.</p>
Business program	A program conducted by a business or ORGANISATION.
Business statement	A policy statement or business plan.
Capital expenditure	<p>Expenditure on capital items incurred by a PARTY.</p> <p>For example, expenditure on land, buildings and medical equipment.</p>
Care plan	<p>A sequenced list of treatments, other services, and resources that are prescribed to improve a PARTY's STATE OF HEALTH AND WELLBEING.</p> <p>For example, a rehabilitation program for a back injury.</p> <p>A CARE PLAN is a scheme which groups and specifies the roles of material or human RESOURCES, planned EVENTS, and PARTYS in providing health and welfare services to an individual or group. A CARE PLAN may not always be formally notified or even documented.</p>
Carer role	<p>A PERSON in their role as a carer of another PERSON or other PERSONS who are ill or disabled and unable to perform the tasks of daily living for themselves.</p> <p>For example, a PERSON providing respite care.</p>
Citizen role	<p>A PERSON, about which information may be required, but who is not engaged in a specific role within the health and welfare sector.</p> <p>For example, the identification of an individual via a Medicare number or of an individual (often anonymously) who is participating in a population-based health or welfare survey.</p>
Community event	<p>An EVENT which is initiated by or affects members of a community.</p> <p>For example, meetings of support groups (e.g. SIDA), and actions or decisions by a community to undertake or not undertake a course of action on such subjects as curfews, right to life, alcohol use and sex education. Extreme examples include protests, demonstrations and riots.</p>

ENTITY NAME	ENTITY DEFINITION
Community organisation	<p>An ORGANISATION operating for the purpose of meeting community needs.</p> <p>For example, a religious, recreational, sporting or volunteer organisation.</p>
Component health and wellbeing	<p>COMPONENT HEALTH AND WELLBEING is a single measure/assessment of the health and wellbeing of a PERSON.</p> <p>For example, diagnosis of an illness, disease or injury, self-assessed health status, financial ability to buy food, and ability to look after oneself.</p>
Crisis event	<p>An acute LIFE EVENT (such as the incidence or prevalence of disease or injury) experienced by a PERSON.</p>
Cultural characteristic	<p>A characteristic of a PERSON which identifies their religious, political, linguistic and ethnic affiliations.</p>
Cultural wellbeing	<p>Those aspects of a PERSON's or community's wellbeing that can be ascribed to cultural factors.</p>
Death event	<p>The EVENT of death.</p> <p>Attributes of this entity would normally include such data elements as date, time and cause of death.</p> <p>The DEATH EVENT does not necessarily imply the end of all EVENTS relating to a PERSON, since EVENTS such as organ donation and transmission of disease may still occur.</p>
Demographic characteristic	<p>A characteristic of a PERSON which contributes to the specification of the population or sub-population to which they belong.</p> <p>For example, sex, country of birth, year of arrival in Australia, Indigenous status etc.</p>
Economic wellbeing	<p>Those aspects of a PERSON's or community's wellbeing that can be ascribed to economic factors.</p> <p>For example, insufficient funds to support an acceptable standard of living.</p>
Education characteristic	<p>A characteristic of a PERSON which relates to their education.</p> <p>For example, highest qualification held and age at leaving school.</p>
Education event	<p>The instance of a PARTY educating another PARTY about the availability, knowledge and access of health and welfare services.</p> <p>For example, school-based drug and alcohol education programs.</p>
Educational system	<p>The public or private provision of education services.</p> <p>For example, the availability of kindergarten, primary school, secondary school and tertiary education facilities in a locality or community.</p>
Employment agreement	<p>An agreement or contract for employing a PERSON and being employed by a PARTY.</p> <p>The EMPLOYMENT AGREEMENT normally involves two PARTYS, one in an employer role and the in an employee role.</p>
Environmental event	<p>A change in the environment which has an effect on one or more PARTYS.</p> <p>Although all EVENTS occur within an environment, the concept of an ENVIRONMENTAL EVENT is an EVENT which has the environment (whether physical, chemical, biological, social, economic, or cultural) as its principal focus. Examples of ENVIRONMENTAL EVENTS include storms, floods and droughts, riots and war, spillage of hazardous chemicals, liquids or gases and economic recession.</p>

ENTITY NAME	ENTITY DEFINITION
Event	<p>Something which happens to or with a PARTY.</p> <p>This entity reflects the emphasis in the model on EVENTS which happen, and which may trigger or influence other EVENTS. Since the model is also date and time stamped at different instances in time, the model can track the development of people and their health and welfare status and wellbeing.</p> <p>EVENT is a major supertype entity in the National Health Information Model.</p>
Exit/leave from service event	<p>The instance of an exit or period of leave by a PERSON from a SERVICE DELIVERY SETTING.</p> <p>For example, a hospital separation or leave from a hospital/nursing home for an agreed period of time.</p>
Expectation	<p>The EXPECTATIONS of a PERSON about health, health care and the health and welfare systems.</p>
Expected outcome	<p>A desired level of attainment to be achieved through one or more HEALTH AND WELFARE SERVICE EVENTS.</p> <p>An outcome in the National Health Information Model most commonly relates to a PERSON but may also be stated for a PARTY or ORGANISATION.</p>
Expenditure	<p>EXPENDITURE on capital items (land, buildings) or indirect EXPENDITURE (patient transport, cleaning services) incurred by an ORGANISATION.</p>
Family member role	<p>A PERSON in their role as a family member.</p> <p>For example, mother, father, guardian, child.</p> <p>A family may or may not live within the same household.</p>
Financial resource item	<p>The existence of funds and budgets to undertake activities.</p> <p>While this entity has no subtypes in the National Health Information Model, it is a major component of health and welfare systems, and one which can and should be separately modelled.</p>
Functional wellbeing	<p>The ability of a PERSON to perform the usual tasks of daily living and to carry out social roles.</p>
Funding agreement	<p>An agreement between PARTYS for the provision and use of funds for a purpose.</p>
Goal/objective	<p>A statement of what is to be achieved in a shorter time frame, as compared with a longer term VISION/MISSION.</p>
Health and welfare policy/plan	<p>A statement or document which may include a VISION, goals, objectives, directions for development, priorities for action, actions to be taken, expected outcomes and performance indicators in relation to HEALTH AND WELFARE PROGRAMs for particular PARTYS, particular locations and particular periods in time.</p> <p>HEALTH AND WELFARE POLICY/PLAN is an entity subtype which reflects instances of policies and plan which are made up of components (HEALTH AND WELFARE POLICY/PLAN ELEMENTs). Other BUSINESS STATEMENTs will exist which are not created for or by the health and welfare sectors but which still impact on a PARTY's STATE OF HEALTH AND WELLBEING.</p>
Health and welfare policy/plan element	<p>A component part of a HEALTH AND WELFARE POLICY/PLAN.</p>

ENTITY NAME	ENTITY DEFINITION
Health and welfare program	<p>A BUSINESS PROGRAM specifically created for or by the health and welfare sectors.</p> <p>HEALTH AND WELFARE PROGRAM is an entity subtype which reflects instances of programs which are made up of components (HEALTH AND WELFARE PROGRAM ELEMENTs). Other BUSINESS PROGRAMs will exist which are not created for or by the health and welfare sectors but which still impact on a PARTY's STATE OF HEALTH AND WELLBEING.</p>
Health and welfare program element	A component of a HEALTH AND WELFARE PROGRAM.
Health and welfare service event	<p>An instance of an EVENT which is part of the delivery or receipt of health and welfare services or care.</p> <p>These EVENTS include delivery of community programs, consultations with service providers, diagnoses, treatment, operations, delivery of care and rehabilitation, delivery of palliative care, counselling services, and voluntary care.</p>
Health status	An instance of the state of health of an individual, group or population measured against accepted standards.
Human resource item	<p>An instance of people with capacity, capability and availability as RESOURCES to provide health and welfare services.</p> <p>This entity will represent the instances of specialist service providers, nurses etc., but can also accommodate voluntary carers as well as the potential to provide services, e.g. a spouse who could care for a partner who became ill. The ideas of skills and expertise are also included in this entity, providing a measure of both capacity and capability.</p> <p>Data elements within this entity reflect the view of the ORGANISATION or employer as compared with data elements within the PERSON ROLE entity which reflect the view of the PERSON in their role as a specialist service provider, nurse etc.</p>
Illness event	<p>An acute or chronic LIFE EVENT experienced by a PERSON but not involving a HEALTH AND WELFARE SERVICE EVENT.</p> <p>For example, the incidence or prevalence of disease.</p>
Information resource item	<p>An instance of information or knowledge which supports the health and welfare system.</p> <p>This broad concept includes what is known about the human body from a medical and scientific perspective, what is known about drugs and interventions, what is known about other factors affecting wellbeing, etc. Research is a process which generates or refines instances of this entity.</p>
Injury event	An acute LIFE EVENT experienced by a PERSON involving the occurrence of an injury but not involving a HEALTH AND WELFARE SERVICE EVENT.
Insurance/benefit characteristic	A characteristic of a PERSON which relates to their health insurance or social security status.
Judicial system	Provision, availability and access to legal services within a community.
Knowledge factor	<p>An instance of a factor that influences, determines or affects a PARTY's state of knowledge or cognisance, particularly of elements of wellbeing, health and welfare, and their services.</p> <p>For example, factors that influence 'How much a person knows about the risks from smoking', 'How much a person knows about the availability of counselling services' and 'How much a service provider knows about the latest technique for treating a particular illness'.</p>

ENTITY NAME	ENTITY DEFINITION
Labour characteristic	<p>A characteristic of a PERSON which relates to the nature of their employment and labour force status. It does not include information collected about a PERSON which relates to their role as a service provider such as usual number of hours worked in a week or hours of overtime.</p> <p>For example, occupation, industry of employment.</p>
Legal characteristic	<p>A characteristic of a PERSON which relates to their legal status.</p> <p>For example, ward of the State, held in custody.</p>
Legal status event	<p>An EVENT which changes a PARTY's legal status.</p> <p>For example, reaching 18 years of age, marriage or the decision by a review board or tribunal to change an individual from 'involuntary' status to 'voluntary' status under the Mental Health Act.</p>
Legally constituted organisation	<p>An ORGANISATION established under law.</p> <p>LEGALLY CONSTITUTED ORGANISATIONS may be ORGANISATIONS in a one-to-one relationship with a statute, (e.g. the Australian Institute of Health and Welfare and the Australian Institute of Health and Welfare Act) or ORGANISATIONS that are examples of a class of ORGANISATION established under and regulated by a statute (e.g. hospitals, incorporated bodies).</p>
Life event	<p>An instance of an EVENT which occurs to or with a PERSON during their life.</p> <p>The LIFE EVENT entity provides the means of identifying those things which happen during a person's life which affect their STATE OF HEALTH AND WELLBEING and occur between their BIRTH EVENT and their DEATH EVENT. This entity does not include events identified elsewhere, e.g. HEALTH AND WELFARE SERVICE EVENTS, COMMUNITY, ENVIRONMENTAL or RESEARCH EVENTS, but does include such things as puberty, the onset of disease, the loss of employment etc. While the actual date and time when some of these events occur may not need to be known or may not be able to be known, this entity provides a means to consistently represent this information.</p>
Lifestyle characteristic	<p>A behavioural attribute, trait or feature of a PERSON that describes an aspect of their lifestyle.</p> <p>For example, cigarette smoking, participation in regular physical exercise, dietary habits, use of illicit drugs etc.</p>
Location	<p>A site or position where something happens, or where a PERSON, group or ORGANISATION is located, may be contacted, conducts their business etc.</p> <p>For example, an ADDRESS or geographical region.</p>
Material resource item	<p>An instance of a material RESOURCE.</p> <p>For example, drugs, buildings, plant, operating theatres, organs, blood products.</p>
Mental wellbeing	<p>The wellbeing of a PERSON, based on their mental state.</p> <p>For example, test results, symptoms, diagnoses and self-perceived health status specific to the mental state of a PERSON.</p>
Natural environment	<p>The NATURAL ENVIRONMENT in which a PERSON or community lives.</p> <p>For example, the quality of air, the quality of water and noise pollution.</p>

ENTITY NAME	ENTITY DEFINITION
Need/issue	<p>The need for, or reason, a PARTY is seeking access to health and welfare services.</p> <p>For example, the need for emergency accommodation.</p> <p>In the National Health Information Model this entity is not intended to represent assessed need (ASSESSMENT EVENT) as determined by a SERVICE PROVIDER. Nor does it represent a STATE OF HEALTH AND WELLBEING of a PARTY once the assessment has been made.</p>
Non-acute event	<p>A non-acute LIFE EVENT experienced by a PERSON but not involving a HEALTH AND WELFARE SERVICE EVENT.</p> <p>For example, the prevalence of chronic disease such as diabetes or asthma.</p>
Organisation	<p>A business or administrative concern created for particular ends.</p>
Organisation characteristic	<p>A characteristic of an ORGANISATION (but unrelated to business factors).</p> <p>For example, the nature of the business or reason for trading.</p> <p>This entity has been included in Version 2.0 of the National Health Information Model as a reflection of the need for descriptive information about an ORGANISATION.</p>
Organisation role	<p>An instance of an ORGANISATION participating in a specific role in the health and welfare sector.</p> <p>For example, an ORGANISATION as a receiver of services or as a provider of services.</p>
Organisation sub-unit	<p>A constituent part of an ORGANISATION.</p> <p>ORGANISATION SUB-UNITs are normally the smaller components of organisations such as departments, divisions, units and sections. ORGANISATION SUB-UNITs may exist in an hierarchical structure.</p>
Organisational setting	<p>An instance of where an EVENT occurs, described in terms of the ORGANISATION.</p> <p>For example, a hospital, a government department.</p>
Other agreement	<p>A BUSINESS AGREEMENT other than a FUNDING AGREEMENT or EMPLOYMENT AGREEMENT.</p> <p>For example, purchaser-provider agreements, and service contracts.</p>
Other crisis event	<p>An acute LIFE EVENT experienced by a PERSON but not involving an illness or injury, or a HEALTH AND WELFARE SERVICE EVENT.</p> <p>For example, emergency accommodation needs and crisis counselling.</p>
Other enabling factor	<p>RESOURCES are a major enabling factor in health and welfare. However, there are other important enabling factors, e.g. access, knowledge and availability, which are recognised by this entity.</p>
Other event	<p>An EVENT which is not a PERSON EVENT, HEALTH AND WELFARE SERVICE EVENT, COMMUNITY EVENT, LEGAL STATUS EVENT, RESEARCH EVENT or ENVIRONMENTAL EVENT.</p>
Other health and welfare service event	<p>A HEALTH AND WELFARE SERVICE EVENT other than a REQUEST FOR/ENTRY INTO SERVICE EVENT, SERVICE PROVISION EVENT, EXIT/LEAVE FROM SERVICE EVENT, ASSESSMENT EVENT, SCREENING EVENT, EDUCATION EVENT, ADVOCACY EVENT, PLANNING EVENT, SURVEILLANCE/MONITORING EVENT, SERVICE SUPPORT EVENT or PAYMENT/CONTRIBUTION EVENT.</p>

ENTITY NAME	ENTITY DEFINITION
Other life event	<p>A LIFE EVENT that a PERSON experiences other than a SELF HELP EVENT or CRISIS EVENT (such as illness or injury).</p> <p>For example, events relating to starting employment, beginning school, pregnancy, menstruation or adoption.</p>
Other organisation role	An instance of an ORGANISATION ROLE within the health and welfare sector which is not as a service provider, service funder or a service purchaser.
Other person characteristic	A characteristic of a PERSON other than a DEMOGRAPHIC CHARACTERISTIC, PHYSICAL CHARACTERISTIC, LABOUR CHARACTERISTIC, LIFESTYLE CHARACTERISTIC, EDUCATION CHARACTERISTIC, SOCIAL CHARACTERISTIC, CULTURAL CHARACTERISTIC, PARENTING CHARACTERISTIC, ACCOMMODATION/HOUSING CHARACTERISTIC, INSURANCE/BENEFIT CHARACTERISTIC or LEGAL CHARACTERISTIC.
Other person role	The role of a PERSON other than as a citizen, family member, carer, advocate, service provider or as a provider of RESOURCES.
Other policy/plan element	Policy and planning elements other than those identified by the HEALTH AND WELFARE POLICY/PLAN ELEMENT subtypes (VISION/MISSION, GOAL/OBJECTIVE, PRIORITY, and PERFORMANCE INDICATORS).
Other role	<p>A ROLE other than a PARTY RELATIONSHIP ROLE, PERSON ROLE, PARTY GROUP ROLE, ORGANISATION ROLE, RECIPIENT ROLE, SERVICE PROVIDER ROLE or RESEARCH ROLE.</p> <p>An expanded list of subtypes relating to PERSONS, PARTY GROUPS and ORGANISATIONS can be found within the entities PERSON ROLE and ORGANISATION ROLE.</p>
Other setting	<p>An instance of where, in generic terms, something happens which is not an ORGANISATIONAL SETTING or a SERVICE DELIVERY SETTING.</p> <p>For example, at home, on a sports field, or at work.</p>
Other social environment	<p>The social environment in which a PERSON or community lives other than the JUDICIAL SYSTEM, the EDUCATIONAL SYSTEM or a COMMUNITY ORGANISATION.</p> <p>For example, the political, economic and cultural environments.</p>
Outcome	A recorded change in the wellbeing of a PARTY which is expected or presumed to be, or to have been, caused by a HEALTH AND WELFARE SERVICE EVENT.
Parenting characteristic	<p>A characteristic of a PERSON which relates to their role as parents.</p> <p>For example, breastfeeding a baby, number of children, and use of child care facilities.</p>
Party	<p>Those PERSONS, groups or ORGANISATIONS who are part of the health and welfare systems, including those who are known to the system and those who are of interest to it. Essentially, this includes all persons in Australia.</p> <p>For example, a PARTY as a recipient of services, provider of services, purchaser of services, or funder of services.</p>
Party group	<p>An instance of a number of PARTYS, normally PERSONS, considered as a collective unit.</p> <p>For example, families, communities and tribes. The Australian population, or sub-populations within it, are represented in the model as a PARTY GROUP.</p>

ENTITY NAME	ENTITY DEFINITION
Party group characteristic	<p>A characteristic of a PARTY GROUP (apart from those associated with an individual or those which are derived from aggregating PERSON data).</p> <p>For example, the main language spoken or religious affiliation of a community.</p> <p>This entity has been included in Version 2.0 of the National Health Information Model as a reflection of the possible need for descriptive information about a PARTY GROUP.</p>
Party group role	<p>An instance of a PARTY GROUP participating in a ROLE within the health and welfare sector.</p>
Party role	<p>An instance of a PARTY participating in a ROLE in the health and welfare sector.</p> <p>The concept of PARTY ROLE in the National Health Information Model provides for different PERSONS, groups and ORGANISATIONS to have different ROLES at different times. Some of these ROLES refer to service delivery, planning, RESOURCE allocation or agreements.</p>
Party relationship role	<p>An instance of a relationship between PARTYS which is relevant to an EVENT.</p> <p>Many of these relationships have been expanded in Version 2.0 of the National Health Information Model and are now found within the expanded entities PARTY ROLE, PARTY GROUP ROLE and ORGANISATION ROLE.</p>
Payment/contribution event	<p>The instance of a PARTY making a payment or contribution as part of their involvement in a HEALTH AND WELFARE SERVICE EVENT.</p> <p>For example, a Medicare payment or a private health fund payment.</p>
Performance goal	<p>A level of performance against which the performance of a PARTY ROLE will be judged.</p>
Performance indicator	<p>A measure of performance.</p> <p>A PERFORMANCE INDICATOR is used to assess performance against goals and targets. PERFORMANCE INDICATOR includes the alternate term of key performance indicators or KPIs.</p>
Person	<p>An individual human being.</p> <p>A PERSON is identified by the ROLE they play. Refer to subtypes within the entity PERSON ROLE. A PERSON will possess a range of characteristics and views. Refer to subtypes within the entity PERSON CHARACTERISTIC and PERSON VIEW, respectively.</p>
Person characteristic	<p>Features which characterise a PERSON.</p> <p>A PERSON CHARACTERISTIC is either a DEMOGRAPHIC CHARACTERISTIC, PHYSICAL CHARACTERISTIC, LABOUR CHARACTERISTIC, LIFESTYLE CHARACTERISTIC, EDUCATION CHARACTERISTIC, SOCIAL CHARACTERISTIC, PARENTING CHARACTERISTIC, ACCOMMODATION/HOUSING CHARACTERISTIC, INSURANCE/BENEFIT CHARACTERISTIC or LEGAL CHARACTERISTIC.</p> <p>This entity reflects the emphasis on the PERSON in the National Health Information Model.</p>
Person event	<p>An EVENT which happens to a PERSON which affects their STATE OF HEALTH AND WELLBEING from the time of their birth until their death.</p>
Person role	<p>An individual in a ROLE as distinct from a PARTY GROUP ROLE or an ORGANISATION ROLE.</p> <p>For example, a PERSON ROLE as a receiver of services, as a provider of services, as a RESOURCE worker within the health and welfare sector etc.</p> <p>The expansion of the PERSON ROLE entity replaces Person Identifier as a subtype of PERSON CHARACTERISTIC from Version 1.0 of the National Health Information Model.</p>

ENTITY NAME	ENTITY DEFINITION
Person view	The ATTITUDEs, BELIEFs, EXPECTATIONs and VALUEs of an individual in relation to health, health care and the health and welfare systems.
Physical characteristic	A characteristic of a PERSON which relates to their physical, chemical and biological characteristics. For example, height, weight, allergies.
Physical environment	The physical environment in which a PERSON or community lives. For example, air and water quality, noise pollution, quality of housing, sanitation.
Physical wellbeing	The wellbeing of a PERSON based on their physical, chemical and biological state.
Planning event	The instance of a PARTY planning an EVENT.
Priority	Something given special attention, normally involving special precedence over others.
Program activity	An identified action to be taken as part of a program or plan. This is distinct from the National Health Information Model entity of EVENT, which is the actual instance or occurrence of these activities.
Program evaluation	A process conducted as part of a program or plan to determine the extent to which the program or plan achieved its GOAL/OBJECTIVE.
Program strategy	An intended course of action to be conducted as part of a program or plan.
Recipient role	An instance of a ROLE a PARTY (usually a PERSON), as a recipient of services or care, plays in EVENTs. For example, a patient, client, consumer, customer.
Recurrent expenditure	EXPENDITURE incurred by a PARTY on a recurring basis for the provision of services, excluding CAPITAL EXPENDITURE, but including indirect EXPENDITURE.
Request for/entry into service event	An instance of a request for services or an entry into a SERVICE DELIVERY SETTING from one service provider to another.
Research event	An instance of a PARTY undertaking research of interest to the health and welfare sector.
Research role	An instance of a ROLE a PARTY plays in research activities.
Resource	The material necessary for an activity. For example, buildings, reusable and consumable items, financial RESOURCEs and people, and the information or knowledge required.
Resource role	An instance of a ROLE a PERSON plays in the management, allocation and use of RESOURCEs. For example, a manager, a cleaner, a computer programmer. A PERSON in a RESOURCE ROLE excludes individuals providing health and welfare services.
Screening event	An instance of a PARTY's involvement in a SCREENING EVENT. For example, mammographic screening, a Pap smear.
Self help event	A PERSON actively seeking help, education or assistance or participating in activities of interest to the health and welfare sector. For example, attending a quit-smoking course or modifying one's diet.

ENTITY NAME	ENTITY DEFINITION
Service delivery setting	<p>A description of a setting where health and welfare services are delivered.</p> <p>For example, a birthing centre, child care centre or hospital emergency department.</p>
Service funder role	<p>An instance of a role an ORGANISATION, as a health and welfare service funder, plays in EVENTS.</p>
Service provider role	<p>The instance of a role, a PERSON, PARTY GROUP or ORGANISATION plays in the provision of health and welfare services, or the health and welfare services that a PERSON, PARTY GROUP or ORGANISATION provides.</p> <p>This includes PERSONS, PARTY GROUPS, and ORGANISATIONS that are formally nominated as service providers (e.g. nurses and general practitioners) and PERSONS, PARTY GROUPS, and ORGANISATIONS that provide voluntary or informal care.</p>
Service provision event	<p>An instance of the provision of a HEALTH AND WELFARE SERVICE EVENT by a service provider to a PERSON or PARTY GROUP.</p> <p>For example, treatment, conducting tests, or counselling.</p>
Service purchaser role	<p>An instance of a role an ORGANISATION, as a health and welfare service purchaser, plays in EVENTS.</p>
Service support event	<p>A planned or actual event which occurs within the domain of a service provider but which is not directly related to the care of PERSON.</p> <p>For example, recruitment, building material acquisition, or building maintenance.</p>
Setting	<p>A description of where something happens.</p> <p>SETTING differs from LOCATION in the National Health Information Model, as an EVENT may occur at the LOCATION of 'Corner of Jones and Smith Streets, SomeCity, WA' (the LOCATION), but it may be better known and more relevant as 'a hospital' (the SETTING).</p>
Social characteristic	<p>A specific social characteristic of a PERSON.</p> <p>For example, marital status, language spoken in the home, or next of kin.</p>
Social environment	<p>The social environment in which a PERSON or community lives, including the JUDICIAL SYSTEM, the EDUCATIONAL SYSTEM or a COMMUNITY ORGANISATION.</p>
Social wellbeing	<p>The wellbeing of a PERSON, based on their interaction with other people.</p> <p>For example, a PERSON's experience with discrimination, racism, violence, family-related matters, gambling or drinking problems.</p>
Specific resource item	<p>The RESOURCES used in the production and delivery of health and welfare services, be they material, financial, human or informational.</p> <p>The SPECIFIC RESOURCE ITEM entity provides for the actual instances of these RESOURCES.</p>
Spiritual wellbeing	<p>The wellbeing of a person, based on their perception of, or relationship to, sacred or religious theory.</p>
Standard	<p>An accepted or approved example of something against which others are judged or measured.</p> <p>Compare with BENCHMARK.</p>

ENTITY NAME	ENTITY DEFINITION
State of health and wellbeing	<p>The measured, assessed or perceived health and wellbeing of a PARTY (usually a PERSON) recorded in aggregate (e.g. the total wellbeing of a PARTY) or component (e.g. a diagnosed illness) terms.</p> <p>For example, SF-36 instrument of health status measurement, an illness diagnosis, an injury, financial ability to buy food, or ability to look after oneself.</p> <p>The STATE OF HEALTH AND WELLBEING entity replaces the State of Wellbeing entity in Version 1.0 of the National Health Information Model.</p>
Stated outcome	<p>The information recorded by a PARTY ROLE about an OUTCOME which has occurred, as distinct from an OUTCOME which was planned or expected. The STATED OUTCOME is distinguished as an entity from the EXPECTED OUTCOME.</p>
Surveillance/monitoring event	<p>The instance of a surveillance or monitoring EVENT within the health and welfare sectors.</p> <p>For example, the conduct of a national/State survey, the establishment of a cancer registry etc.</p>
Value	<p>The VALUES of a PERSON about health, health care and the health and welfare sectors.</p>
Vision/mission	<p>The highest level statement of why something is to happen or where a situation or organisation should be in a set period of time. Vision or mission statements normally contain the aspirations of those stating them.</p>

Appendix D: Cross-classificatory variables – staffing category

The following definitions of staffing categories used in the data elements Full-time equivalent staff and Salaries and wages are presented in an abbreviated form in Version 8.0 of the Dictionary. A more detailed list is provided in Version 6 of the *National Health Data Dictionary*.

C1: Staffing category	Definition
C1.1: Salaried medical officers	<p>Medical officers employed by the hospital on a full-time or part-time salaried basis. This excludes visiting medical officers engaged on an honorary, sessional or fee-for-service basis.</p> <p>This category includes salaried medical officers who are engaged in administrative duties regardless of the extent of that engagement (for example, clinical superintendent and medical superintendent).</p>
C1.2 Registered nurses	<p>Registered nurses include persons with at least a three-year training certificate and nurses holding post-graduate qualifications. They must be registered with the State or Territory registration board. This is a comprehensive category and includes community mental health, general nurse, intellectual disability nurse, midwife (including pupil midwife), psychiatric nurse, senior nurse, charge nurse (now unit manager), supervisory nurse and nurse educator.</p> <p>This category also includes nurses engaged in administrative duties no matter what the extent of their engagement, for example, directors of nursing and assistant directors of nursing.</p>
C1.3: Enrolled nurse	<p>Enrolled nurses are second-level nurses who are enrolled in all States and Territories except Victoria where they are registered by the State or Territory registration board to practise in this capacity. This category includes general enrolled nurses and specialist enrolled nurses (e.g. mothercraft nurses in some States).</p>
C1.4: Establishment-based student nurses	<p>Student nurses are persons employed by the establishment currently enrolled in a three-year certificate course. This includes any person commencing or undertaking a three-year course of training leading to registration as a nurse by the State or Territory registration board. This includes full-time general student nurses and specialist student nurses, such as mental deficiency nurses, but excludes practising nurses enrolled in post-basic training courses.</p>
C1.5: Trainee/pupil nurse	<p>Trainee/pupil nurses include any person commencing or undertaking a one-year course of training leading to registration as an enrolled nurse on the State or Territory registration board (includes all trainee nurses).</p>
C1.6: Other personal care staff	<p>This category includes attendants, assistants or home assistants, home companions, family aides, ward helpers, wardsmen, orderlies, ward assistants and nursing assistants engaged primarily in the provision of personal care to patients or residents, who are not formally qualified or undergoing training in nursing or allied health professions.</p>
C1.7: Diagnostic and health professionals	<p>Qualified staff (other than qualified medical and nursing staff) engaged in duties of a diagnostic, professional or technical nature (but also including diagnostic and health professionals whose duties are primarily or partly of an administrative nature). This category includes all allied health professionals and laboratory technicians (but excludes civil engineers and computing staff).</p>
C1.8: Administrative and clerical staff	<p>Staff engaged in administrative and clerical duties. Medical staff and nursing staff, diagnostic and health professionals and any domestic staff primarily or partly engaged in administrative and clerical duties are excluded. Civil engineers and computing staff are included in this category.</p>
C1.9: Domestic and other staff	<p>Domestic staff are staff engaged in the provision of food and cleaning services including domestic staff primarily engaged in administrative duties such as food services manager. Dieticians are excluded.</p> <p>This category also includes all staff not elsewhere included (primarily maintenance staff, tradespersons and gardening staff).</p>

Appendix E: Establishment – activity definitions

The objective of having data definitions related to the activities of health care establishments is to enable a description of health service systems, including the type of care delivered by the establishment. The unit of enumeration is a separately administered establishment. The term 'establishment' is used in a very broad sense to mean organisational units, whether institutions, organisations or community-based services, which provide health services. Establishments are considered to be separately administered if the finances, budget and activities are managed as an independent unit. The term establishment thus covers conventional establishments such as hospitals, residential aged care facilities and community health centres, but is also used to cover organisations providing services in the community (e.g. domiciliary nursing services) or support services to other establishments (e.g. a centralised pathology laboratory service). The situation where establishment-level data for components of an area health service are not available separately at a central authority, is not grounds for treating such a group of establishments as a single establishment unless such data are not available at any level in the health care system.

Two major measures of service provision are defined for each establishment. They are the recording of services by type of episode (admitted patients) and by service type (non-admitted patients). As there are no nationally agreed data definitions at the person-level for non-admitted patients or for outreach/community clients, definitions for non-admitted patient activity are based on a cost centre or functional unit approach; that is, where the service was performed rather than the procedure or the diagnosis of the patient.

The activity for acute care hospitals is represented as a count of separations and patient-days for admitted patients according to the treatment mode categories same-day and overnight-stay.

The number of separations for renal dialysis and endoscopy and related procedures are identified separately for admitted and non-admitted patients. This enables comparison of the provision of these services across institutional settings, whether these patients are admitted or treated as non-admitted patients.

Separations and patient-days for admitted patients are contrasted with an occasion of service or group session as a measure of non-admitted patient activity. It is recognised that the comparison of these as a measure of activity is not ideal but it will be used until a more comprehensive set of definitions is developed to describe patients treated and non-admitted patient activity.

The number of separations, patient days and occasions of service is the measure of activity for same-day establishments and for acute hospitals.

The definition and counting of separations and patient-days for public psychiatric and alcohol and drug treatment centres is the same as for the acute care hospitals, except that the treatment mode category is expanded to distinguish between short-stay and long-stay patients. This is to reflect the greater percentage of patients with extended lengths of stay in these institutions.

Appendix F: Establishment – resource use definitions

The use of resources (facilities, financial and human) in health services is a major focus of interest to all users of information published using the definitions contained in the *National Health Data Dictionary*. Uniform data definitions on the health care institutions of the States, Territories, the Commonwealth and the private sector are needed to obtain a comprehensive picture of resource use. The main categories of resource data that are defined at the establishment level are:

- establishment characteristics (type and location);
- staffing data (full-time equivalent staff);
- recurrent expenditure (salary and non-salary); and

revenue.

Significant measures of resources not included above are capital expenditure, physical details and monetary values of major buildings, facilities, equipment, plant and so on. Capital expenditure is included in the *National Health Data Dictionary* at the system level (see Appendix G), but the formation of detailed uniform data definitions to describe items relating to facilities and equipment has yet to be agreed on and implemented. The classification of the type of establishment is currently under review by the Organisational Units Working Group, which is expected to report to the National Health Data Committee in 1999.

Financial aspects

The establishment of the National Minimum Data Sets was not seen as an appropriate vehicle for undertaking a review of national accounting practice. During the formation of the definitions it was inevitable that some aspects of accounting practice were discussed (e.g. offsetting practices). The *National Health Data Dictionary* makes reference to established accounting standards with Accounting Standard 17 in relation to financial and operating leases and Accounting Standard 4 in relation to the depreciation of non-current assets. The absence of completely uniform accounting standards and practices for health institutions between and within States and limits the comparability of financial data. The directors of finance of the State and Territory government health authorities are developing national expenditure reporting standards, with particular regard to hospitals.

Standard national health expenditure definitions

The development of agreed definitions on the major areas of health expenditure is being undertaken through the National Health Information Work Program. A set of definitions has been adopted by the Australian Bureau of Statistics for use in public finance statistics and is being discussed and refined in consultation with key stakeholders, including State and Territory government directors of finance.

Boundaries between capital and recurrent expenditure

Some differences exist in the practice of differentiating between capital and recurrent expenditure in the States and Territories. The definition of capital expenditure is included in the Dictionary and recurrent expenditure is implicitly defined as that part of total expenditure which is not capital expenditure. The major difference with regard to capital expenditure, between the States and Territories is in regard to the level of capitalisation. The Dictionary states that 'the minimum level for capitalisation is no higher than \$5000', and some States use \$5000 but others use \$1000 or lower.

Offsetting practices

As a general rule, offsetting revenue against related expenditure is not good accounting practice and both gross revenue and gross expenditure should be reported. However, it is recognised that there are circumstances (such as hospital to hospital transfers/ services) where offsetting is done to avoid the duplication of costs. Where it is difficult to identify specific costs in relation to inter-hospital transfers, the practice of bringing in revenue to inter-hospital services through recoveries is considered acceptable.

Appendix G: System-level resource definitions

System-level definitions relate to all of a particular type of establishment, such as public hospitals or community health centres, at the State, Territory, or Commonwealth level (whichever is the highest level of overall administration of the system). The data definitions in the *National Health Data Dictionary* at the system or State health authority level are related to capital expenditure and indirect health care expenditure.

Capital expenditure

A working party of the National Health Data Committee developed a new definition of capital expenditure during 1994. The National Health Information Management Group agreed that both the new definition (previously known as item S1b) and the former definition (previously known as item S1a) would be current in the dictionary until all relevant jurisdictions implemented accrual accounting procedures.

Indirect health care expenditure

The system-level definitions represent expenditure on health care that cannot be directly related to programs operated by a particular establishment but that can be indirectly related to the admitted patients, residents, non-admitted patients, non-residents and community/outreach patients served by that establishment. These definitions are designed to improve the overall picture of health expenditure and to assist in understanding differences in costs for similar establishments in different States and regions. They are also designed to detect differences in the extent to which support services and other services to resident/admitted patients and non-admitted patients of an establishment may be provided by the establishment itself, at a State level or by other organisations. This concept will be reviewed by the National Health Data Committee during 1999.

Glossary of terms

The following glossary of terms supports the definitions of capital expenditure:

Asset

An asset is the service potential and/or future economic benefit controlled by the reporting entity as a result of past transactions or other past events including:

- Physical assets
 - current physical assets
 - non-current physical assets
- intangible assets.

The 'service potential' of an asset is its economic utility to the entity, based on the total benefit expected to be derived by the entity from the use of the asset and/or the subsequent disposal of the asset.

Financial asset

A financial asset is an asset that has a counterpart liability in the books of another accounting entity. For the purpose of the *National Health Data Dictionary*, financial assets are excluded.

Control

The recognition of an asset is based on the test of control rather than ownership. This may result in assets being recognised by a reporting agency that is not the registered owner (for example, denominational/ third schedule/non-profit hospitals). Control is the capacity of the entity to benefit from the asset in pursuit of the entity objectives and to deny or regulate the access of others to that benefit.

Ownership of an asset occurs when the asset is purchased by or donated to an accounting entity. Acquisition means undertaking the risks, and receiving the rights to future benefits, as would be conferred with ownership, in exchange for a cost of acquisition.

Note: In cases where there is a building providing public health services under government control situated on land owned by a non-profit organisation, the value of the building, but not that of the land, should be included as a public asset.

Asset capitalisation

Asset capitalisation occurs when an item of expenditure meets the criteria of an asset and:

- is recorded in the books of an accounting entity;
- is recorded in an asset management system and depreciated; and
- the minimum level for capitalisation is no higher than \$5,000.

Asset disposal

When an asset is considered unserviceable, obsolete or in excess of probable requirements, it is disposed of using designated procedures. The asset is removed from both the accounting entity's asset management system and the book of accounts.

Asset enhancement

Expenditure on an existing asset is to be treated as an enhancement where there has been an effective and significant increase in the present or planned service potential of the asset. If the increase in service potential is incidental to some necessary maintenance and the incremental level will not be used in the foreseeable future, the expenditure would be more appropriately classified as maintenance.

Service potential has three components:

Service capacity: The expenditure increases the capacity to provide services and meet increases in demand for the asset's services.

Service quality: Improvement in the standard of the service provided, including efficiency improvements such as cost reductions, can represent an enhancement to an existing asset.

Useful life: The initial assessment of an asset's useful life will have assumed that certain maintenance expenditure (both routine and major periodic) would be necessary for the asset to achieve its anticipated useful life. An expenditure can only be accounted for as an enhancement if it increases (rather than assumes the achievement of) the asset's pre-determined useful life. This would include major work undertaken to extend the service potential of an asset, recognising that its function may change (e.g. refurbishment). It may result in a need to re-assess the life span of the asset.

Grouped assets

Most assets, particularly system assets, consist of a number of components. In principle, each component can provide service potential or future economic benefit and can therefore be classified as an asset. In practice, however, the key criterion for a separate asset is that it is an independent operating unit the components of which function as a cohesive whole to provide a common service. Such a unit is referred to as a 'grouped asset'.

For example, a computer network operates as a cohesive whole, yet may contain individual personal computers that can also operate independently. A network of roads, a water sewerage system, an electricity distribution system and a communications network are examples of extensive and integrated components operating as part of a total asset system. Another example of a group of assets used together to provide a common service is office furniture and equipment.

Grouped assets (including network assets) should be primary units for accounting recognition because their components function as a cohesive whole to provide a common service. This is subject to the capitalisation threshold.

The threshold tests should be applied to individual assets as well as grouped assets. The cost of each item making up a set of office furniture or of each computer in a computer network may be less than the capitalisation threshold, but if the total cost of the network or grouped asset exceeds the threshold, each item should be capitalised.

Cost of acquisition

The cost of acquisition is the purchase consideration (price) paid for an asset plus any costs incidental to the acquisition. The cost of an asset must include (where appropriate):

- installation
- commissioning
- transport
- customs duty
- any other incidental costs.

Interest and other finance costs incurred in acquiring the service potential embodied in an asset (for example, exchange fluctuations on loans) should not be included in the acquisition cost of that asset.

Asset construction

The following costs should be included in relation to construction of an asset:

- Costs that relate directly to the construction of an asset, including:
 - direct labour and material costs;
 - depreciation of physical non-current assets used on construction of the asset; and
 - set up costs directly related to the construction of an asset.
- Costs that are reliably attributable to the construction activity and are capable of being allocated on a reasonable basis to specific assets, including:
 - purchasing administration costs;
 - insurance;
 - costs of design and technical activities; and
 - project overheads (such as direct administration and holding costs of the project).
- The following costs, which are related to activities of the agency or asset construction generally, but not specific to the asset being constructed, should be excluded as they cannot be reliably attributed to the asset:
 - general administration costs; and
 - depreciation of plant and equipment not related to construction activities (including idle plant and equipment).

Lease

A lease is a grant or possession of an asset for a stated period of time at specified rentals and subject to various conditions. The register proprietor has certain re-entry rights if the lessee defaults by not observing the conditions of the lease or by not paying the specified rentals.

Appendix H: National Minimum Data Sets

Name: Institutional health care

Start date: 1/7/1989

Scope: Patient-level data (morbidity data)

The scope of this minimum data set is admitted patients in all public and private acute and psychiatric hospitals, free-standing day hospital facilities and alcohol and drug treatment centres.

Hospitals operated by the Australian Defence Force, corrections authorities and Australia's external Territories are not currently included. Hospitals specialising in dental, ophthalmic aids and other specialised acute medical or surgical care are included.

The collection period is the financial year ending 30 June. As a patient may enter hospital several times during a collection period (for either the same condition or different conditions), and the episodes for any one person are not linked, the published statistics relate to separations and not patients.

Establishment-level data

The scope of this minimum data set is public acute and psychiatric hospitals, including hospitals operated for or by the Department of Veterans' Affairs, and alcohol and drug treatment centres.

Similar data for private hospitals and free-standing day hospital facilities are collected by the Australian Bureau of Statistics in the Private Health Establishments Collection.

Hospitals operated by the Australian Defence Force, corrections authorities and Australia's external Territories are not currently included. Hospitals specialising in dental, ophthalmic aids and other specialised acute medical or surgical care are included.

Data elements included in the NMDS as at 1 July 1999:

Data element	Start date
Activity when injured, version 1	1/7/1998
Acute care episode for admitted patients, version 1	1/7/1995
Additional diagnosis, version 4	1/7/1998
Administrative expenses, version 1	1/7/1989
Admission, version 2	1/7/1989
Admission date, version 4	1/7/1989
Area of usual residence, version 3	1/7/1997
Capital expenditure, version 1	1/7/1989
Capital expenditure - gross (accrual accounting), version 2	1/7/1997
Capital expenditure - net (accrual accounting), version 2	1/7/1997
Compensable status, version 2	1/7/1993
Country of birth, version 1	1/7/1994
Date of Birth, version 2	1/7/1994
Depreciation, version 1	1/7/1989
Diagnosis related group, version 1	1/7/1993
Domestic services, version 1	1/7/1989
Drug supplies, version 1	1/7/1989
Establishment number, version 2	1/7/1997
Establishment sector, version 2	1/7/1997
Establishment type, version 1	1/7/1989
External cause - admitted patient, version 4	1/7/1998
Food supplies, version 1	1/7/1989
Full-time equivalent staff, version 2	1/7/1997
Geographical location of establishment, version 2	1/7/1997
Group sessions, version 1	1/7/1989
Hospital, version 1	1/7/1994

Data element	Start date
Hospital boarder, version 1	1/7/1994
Hospital insurance status, version 3	1/7/1997
Indigenous status, version 2	1/7/1997
Indirect health care expenditure, version 1	1/7/1989
Individual/group session, version 1	1/7/1989
Infant weight, neonate, stillborn, version 3	1/7/1997
Intended length of hospital stay, version 1	1/7/1995
Interest payments, version 1	1/7/1989
Inter-hospital same-day contracted patient, version 1	1/7/1994
Live birth, version 1	1/7/1994
Major diagnostic category, version 1	1/7/1993
Medical and surgical supplies, version 1	1/7/1989
Mental health legal status, version 4	1/7/1999
Mode of admission, version 4	1/7/1999
Mode of separation, version 2	1/7/1993
Neonate, version 1	1/7/1995
Non-admitted patient, version 1	1/7/1994
Number of available beds for admitted patients, version 2	1/7/1997
Number of leave periods, version 3	1/7/1996
Occasions of service, version 1	1/7/1989
Other recurrent expenditure, version 1	1/7/1989
Other revenues, version 1	1/7/1989
Overnight-stay patient, version 1	1/7/1994
Patient, version 1	1/7/1995
Patient accommodation eligibility status, version 2	1/7/1993
Patient days, version 2	1/7/1995
Patient revenue, version 1	1/7/1989
Patient transport, version 1	1/7/1989
Payments to visiting medical officers, version 1	1/7/1989
Person identifier, version 1	1/7/1989
Place of occurrence of external cause of injury – admitted patient, version 4	1/7/1998
Principal diagnosis, version 3	1/7/1998
Procedure, version 5	1/7/1999
Recoveries, version 1	1/7/1989
Region code, version 2	1/7/1997
Repairs and maintenance, version 1	1/7/1989
Salaries and wages, version 1	1/7/1989
Same-day patient, version 1	1/7/1994
Separation, version 2	1/7/1999
Separation date, version 5	1/7/1999
Separations, version 2	1/7/1994
Sex, version 2	1/7/1994
Source of referral to acute hospital or private psychiatric hospital, version 3	1/7/1997
Source of referral to public psychiatric hospital, version 3	1/7/1997
Specialised service indicators, version 1	1/7/1989
State identifier, version 2	1/7/1997
Superannuation employer contributions (including funding basis), version 1	1/7/1989
Teaching status, version 1	1/7/1989
Total leave days, version 3	1/7/1996
Total psychiatric care days, version 2	1/7/1998
Treatment mode, version 2	1/7/1994
Type of episode of care, version 3	1/7/1998
Type of non-admitted patient care, version 1	1/7/1994
Type of non-admitted patient care (public psychiatric, alcohol and drug), version 1	1/7/1989

Name: Institutional mental health care

Start date: 1/7/1997

Scope: The scope of this minimum data set is restricted to admitted patients receiving care in psychiatric hospitals or in designated psychiatric units in acute hospitals. The scope does not currently include patients who may be receiving treatment for psychiatric conditions in acute hospitals who are not in psychiatric units.

Data elements included in the NMDS as at 1 July 1999:

Data element	Start date
Additional diagnosis, version 4	1/7/1998
Admission date, version 4	1/7/1997
Area of usual residence, version 3	1/7/1997
Compensable status, version 2	1/7/1997
Country of birth, version 2	1/7/1997
Date of birth, version 2	1/7/1997
Diagnosis related group, version 1	1/7/1997
Employment status – acute hospital and private psychiatric hospital admissions, version 2	1/7/1997
Employment status – public psychiatric hospital admissions, version 2	1/7/1997
Establishment identifier, version 2	1/7/1997
Establishment number, version 2	1/7/1997
Establishment sector, version 2	1/7/1997
Hospital insurance status, version 3	1/7/1997
Indigenous status, version 2	1/7/1997
Major diagnostic category, version 1	1/7/1997
Marital status, version 2	1/7/1997
Mental health legal status, version 4	1/7/1999
Mode of admission, version 4	1/7/1999
Mode of separation, version 2	1/7/1997
Number of leave periods, version 3	1/7/1997
Patient accommodation eligibility status, version 2	1/7/1997
Pension status – psychiatric patients, version 2	1/7/1997
Person identifier, version 1	1/7/1997
Previous specialised treatment, version 3	1/7/1999
Principal diagnosis, version 3	1/7/1998
Region code, version 2	1/7/1997
Separation date, version 5	1/7/1999
Sex, version 2	1/7/1997
State identifier, version 2	1/7/1997
Total leave days, version 3	1/7/1997
Total psychiatric care days, version 2	1/7/1998
Type of accommodation, version 2	1/7/1999
Type of episode of care, version 3	1/7/1998
Type of usual accommodation, version 1	1/7/1997

Name: **Community mental health care**

Start date: **1/7/1998**

Scope: Data required for reporting by specialised psychiatric services that deliver ambulatory services, in both institutional and community settings and/or community-based residential care. It does not extend to services provided to patients who are in general (non-specialised) care who may be receiving treatment or rehabilitation for psychiatric conditions.

The data provided through the National Minimum Data Set – Community mental health care supplements that reported for psychiatric and acute care hospitals through the National Minimum Data Set – Institutional mental health care.

Data elements included in the NMDS as at 1 July 1999:

Data element	Start date
Additional diagnosis, version 4	1/7/2000
Administrative expenses, version 1	1/7/1998
Date of Birth, version 2	1/7/2000
Depreciation, version 1	1/7/1998
Domestic services, version 1	1/7/1998
Drug supplies, version 1	1/7/1998
Establishment identifier, version 2	1/7/1998
Food supplies, version 1	1/7/1998
Geographical location of establishment, version 2	1/7/1998
Indigenous status, version 2	1/7/2000
Interest payments, version 1	1/7/1998
Medical and surgical supplies, version 1	1/7/1998
Mental health legal status, version 4	1/7/2000
Non-salary operating costs, version 1	1/7/1998
Number of available beds for admitted patients, version 2	1/7/1998
Number of contacts (psychiatric outpatient clinic/day program), version 1	1/7/2000
Number of service contact dates, version 2	1/7/2000
Other recurrent expenditure, version 1	1/7/1998
Patient transport, version 1	1/7/1998
Payments to visiting medical officers, version 1	1/7/1998
Person identifier, version 1	1/7/2000
Principal diagnosis, version 3	1/7/2000
Repairs and maintenance, version 1	1/7/1998
Salaries and wages, version 1	1/7/1998
Separations, version 2	1/7/1998
Sex, version 2	1/7/2000
Superannuation employer contributions (including funding basis), version 1	1/7/1998
Total psychiatric care days, version 2	1/7/2000

Name: Elective surgery waiting times

Start date: 1/7/1994

Scope: The scope of this minimum data set is based on waiting lists for elective surgical care in public acute hospitals.

Hospitals operated by the Australian Defence Force, corrections authorities and Australia's external Territories are not currently included.

To monitor time waited by patients who are yet to be admitted to hospital, the scope is patients on or removed from the waiting lists on a date or during a period.

To monitor time waited by patients who have been admitted for elective care, the scope is patients admitted to hospital from the elective surgical waiting list.

Hospitals operated by the Australian Defence Forces, corrections authorities and Australia's external Territories are excluded.

Data elements included in the NMDS as at 1 July 1999:

Data Element	Start Date
Category reassignment date, version 2	1/7/1997
Census date, version 2	1/7/1997
Clinical review, version 1	1/7/1997
Clinical urgency, version 2	1/7/1997
Elective care, version 1	1/7/1997
Elective surgery, version 1	1/7/1997
Extended wait patient, version 1	1/7/1999
Hospital census, version 1	1/7/1997
Hospital waiting list, version 1	1/7/1997
Indicator procedure, version 3	1/7/1997
Listing date, version 2	1/7/1997
Non-elective care, version 1	1/7/1996
Overdue patient, version 3	1/7/1997
Patient listing status, version 3	1/7/1997
Reason for removal, version 2	1/7/1997
Surgical specialty, version 1	1/7/1995
Waiting list category, version 3	1/7/1995
Waiting time at a census date, version 1	1/7/1999
Waiting time at admission, version 1	1/7/1999

Name: **Emergency Department waiting times**

Start date: **1/7/1999**

Scope: The scope of this minimum data set is to be negotiated between Commonwealth and State and Territory Government health authorities. It is likely that data will only be required for reporting by metropolitan hospitals and larger rural and regional hospitals.

Data elements included in the NMDS as at 1 July 1999:

Data element	Start date
Date of triage, version 1	1/7/1999
Date of service event, version 1	1/7/1999
Date patient presents, version 1	1/7/1999
Departure status, version 1	1/7/1999
Emergency Department waiting time to service delivery, version 1	1/7/1999
Establishment number, version 2	1/7/1999
Patient presentation at Emergency Department, version 1	1/7/1999
Time of triage, version 1	1/7/1999
Time patient presents, version 1	1/7/1999
Triage category, version 1	1/7/1999
Type of visit, version 1	1/7/1999

Name: **Health labour force**

Start date: **1/7/1989**

Scope: The scope of this set of data elements is all health occupations. National collections using this data set have been undertaken for the professions of medicine, nursing, dentistry, pharmacy, physiotherapy and podiatry, using labour force questionnaires in the annual renewal of registration to practice.

Data elements included in the NMDS as at 1 July 1999:

Data element	Start date
Classification of health labour force job, version 1	1/7/1995
Date of birth, version 2	1/7/1995
Health labour force, version 1	1/7/1995
Hours worked by health professional, version 2	1/7/1997
Hours worked by medical practitioner in direct patient care, version 2	1/7/1997
Hours on-call (not worked) by medical practitioner, version 2	1/7/1997
Principal area of clinical practice, version 1	1/7/1995
Principal status of health professional, version 1	1/7/1995
Profession labour force status of health professional, version 1	1/7/1995
Total hours worked by medical practitioner, version 2	1/7/1997
Type and sector of employment establishment, version 1	1/7/1995

Name: Injury surveillance

Start date: 1/7/1989

Scope: The scope of this minimum data set is patient level data from selected emergency departments of hospitals and other settings.

Data elements included in the NMDS as at 1 July 1999:

Data element	Start date
Activity when injured, version 1	1/7/1996
Bodily location of main injury, version 1	1/7/1996
External cause – admitted patient, version 4	1/7/1998
External cause – human intent, version 4	1/7/1998
Narrative description of injury event, version 1	1/7/1996
Nature of main injury – non-admitted patient, version 1	1/7/1996
Place of occurrence of external cause of injury – admitted patient, version 4	1/7/1998
Place of occurrence of external cause of injury – non-admitted patient, version 3	1/7/1997

Name: Palliative care

Start date: 1/7/2000

Scope: At present, the scope of this minimum data set is admitted patients in all public and private acute hospitals, and free-standing day hospital facilities. Hospitals operated by the Australian Defence Force, corrections authorities and Australia's external Territories are not currently included.

Data elements included in the NMDS as at 1 July 1999:

Data element	Start date
Additional diagnosis, version 4	1/7/2000
Admission date, version 4	1/7/2000
Area of usual residence, version 3	1/7/2000
Country of birth, version 2	1/7/2000
Date of birth, version 2	1/7/2000
Establishment identifier, version 2	1/7/2000
Indigenous status, version 2	1/7/2000
Mode of admission, version 4	1/7/2000
Mode of separation, version 2	1/7/2000
Person identifier, version 1	1/7/2000
Previous specialised treatment, version 3	1/7/2000
Principal diagnosis, version 3	1/7/2000
Separation date, version 5	1/7/2000
Sex, version 2	1/7/2000
Type of episode of care, version 3	1/7/2000

Name: Perinatal

Start date: 1/7/1997

Scope: The scope of this minimum data set is all births in Australia in hospitals, birth centres and the community. The data set includes information on all births, both live and stillborn, of at least 20 weeks gestation or 400 grams birthweight.

Data elements included in the NMDS as at 1 July 1999:

Data element	Start date
Actual place of birth, version 1	1/7/1997
Birth order, version 1	1/7/1997
Birth plurality, version 1	1/7/1997
Birthweight, version 1	1/7/1997
Country of birth, version 2	1/7/1997
Date of birth, version 2	1/7/1997
Establishment identifier, version 2	1/7/1997
Establishment number, version 2	1/7/1997
Establishment sector, version 2	1/7/1997
First day of last menstrual period, version 1	1/7/1997
Gestational age, version 1	1/7/1997
Indigenous status, version 2	1/7/1997
Infant weight, neonate, stillborn, version 3	1/7/1997
Live birth, version 1	1/7/1997
Method of birth, version 1	1/7/1997
Neonate, version 1	1/7/1997
Neonatal death, version 1	1/7/1997
Onset of labour, version 1	1/7/1997
Perinatal period, version 1	1/7/1997
Person identifier, version 1	1/7/1997
Region code, version 2	1/7/1997
Separation date, version 5	1/7/1999
Sex, version 2	1/7/1997
State identifier, version 2	1/7/1997
State/Territory of birth, version 1	1/7/1997
Status of the baby, version 1	1/7/1997
Stillbirth (foetal death), version 1	1/7/1997

Appendix I: Data elements listed by previous 'P', 'A', 'E', and 'S' numbers

This section contains data elements from Version 6 that are included in Version 8.0, listed by the old 'P', 'A', 'E' and 'S' numbering system. This list does not include data element concepts, and new elements introduced for Version 7.0 or Version 8.0, as these do not have 'P', 'A', 'E' or 'S' numbers allocated to them.

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A9	Type of non-admitted patient care, version 1	397
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A11	Type of non-admitted patient care (nursing homes and hostels), version 1	401
A12	Individual/group session, version 1	330
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E11	Drug supplies, version 1	211
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DE #	DATA ELEMENT NAME	Page no.
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P1	Establishment number, version 2	173
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P5	Date of birth, version 2	4
P6	Country of birth, version 2	3
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Appendix J: Data elements – by Knowledgebase ID number

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000001	Indigenous status, version 2
000002	Activity when injured, version 1
000003	Actual place of birth, version 1
000004	Acute care episode for admitted patients (<i>concept</i>), version 4
000005	Additional diagnosis, version 4
000007	Admission (<i>concept</i>), version 1
000008	Admission date, version 4
000009	Number of days in special/neonatal intensive care, version 2
000010	Infant weight, neonate, stillborn, version 3
000011	Admitted patient (<i>concept</i>), version 2
000013	Anaesthesia administered during labour, version 1
000014	Analgesic administered during labour, version 1
000016	Area of usual residence, version 3
000018	Behaviour-related nursing requirements – at nursing home admission, version 1
000019	Birth order, version 1
000020	Birth plurality, version 1
000021	Birthweight (<i>concept</i>), version 1
000022	Carer availability, version 2
000023	Classification of health labour force job, version 1
000024	Clinical review (<i>concept</i>), version 1
000025	Clinical urgency, version 2
000026	Compensable status, version 2
000027	Complication of labour and delivery, version 2
000028	Complications of pregnancy, version 2
000029	Congenital malformations – BPA code, version 1
000030	Congenital malformations, version 2
000033	Continence status (faeces) of nursing home resident – at admission, version 2
000034	Continence status (faeces) of nursing home resident – current status, version 2
000035	Country of birth, version 2
000036	Date of birth, version 2
000037	Date of completion of last previous pregnancy, version 1
000038	Date of first delivery of service, version 2
000039	Date of first contact, version 2
000040	Date of last contact, version 2
000042	Diagnosis related group, version 1
000043	Separation date, version 5 [∇]
000046	Elective surgery (<i>concept</i>), version 1
000050	Establishment identifier, version 2
000053	External cause – admitted patient, version 4
000053	External cause – human intent, version 4

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Knowledgebase ID no.	Data element name
000056	First day of the last menstrual period, version 1
000057	Functional profile of nursing home resident – at admission, version 1
000058	Functional profile of nursing home resident – current status, version 1
000059	Gestational age (<i>concept</i>), version 1
000060	Gestational age, version 1
000061	Health labour force (<i>concept</i>), version 1
000062	Health outcome (<i>concept</i>), version 1
000063	Health outcome indicator (<i>concept</i>), version 1
000064	Hospital (<i>concept</i>), version 1
000065	Hospital boarder (<i>concept</i>), version 1
000066	Hospital census (<i>concept</i>), version 1
000067	Hospital waiting list (<i>concept</i>), version 1
000073	Indicator procedure, version 3
000075	Hospital insurance status, version 3
000076	Intended length of hospital stay, version 1
000077	Intended place of birth, version 1
000078	Intensive Care Unit (<i>concept</i>), version 1
000079	Inter-hospital same-day contracted patient, version 1
000082	Listing date, version 2
000083	Live birth (<i>concept</i>), version 1
000084	Location immediately prior to admission to nursing home, version 1
000085	Overdue patient, version 3
000086	Bodily location of main injury, version 1
000087	Nature of main injury – non-admitted patient, version 1
000088	Major diagnostic category, version 1
000089	Marital status, version 2
000090	Maternal medical conditions, version 1
000091	Medicare number, version 1
000092	Mental health legal status, version 4 [∇]
000093	Method of birth, version 1
000094	Minutes of operating theatre time, version 1
000096	Mode of separation, version 2
000099	Narrative description of injury event, version 1
000100	Need for interpreter service, version 1
000101	Neonatal death (<i>concept</i>), version 1
000102	Neonatal morbidity, version 2
000103	Neonate (<i>concept</i>), version 1
000104	Non-admitted patient (<i>concept</i>), version 1
000105	Non-elective care (<i>concept</i>), version 1
000107	Number of leave periods, version 3
000110	Nursing diagnosis, version 2
000111	Goal of care, version 2
000112	Nursing interventions, version 2
000113	Onset of labour, version 1
000114	Outcome of last previous pregnancy, version 1

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Knowledgebase ID no.	Data element name
000116	Overnight-stay patient (<i>concept</i>), version 1
000117	Patient (<i>concept</i>), version 1
000118	Patient accommodation eligibility status, version 2
000119	Length of stay, version 1
000120	Patient listing status, version 1
000121	Pension status – psychiatric patients, version 2
000124	Perinatal period (<i>concept</i>), version 1
000125	Perineal status, version 1
000126	Period of residence in Australia, version 1
000127	Person identifier, version 1
000128	Place of occurrence of external cause of injury – non-admitted patient, version 4
000131	Postpartum complication, version 2
000132	Preferred language, version 2
000133	Presentation at birth, version 1
000134	Previous pregnancies, version 1
000135	Principal area of clinical practice, version 1
000136	Principal diagnosis, version 3
000137	Procedure, version 5 [∇]
000138	Principal role of health professional, version 1
000139	Previous specialised treatment, version 3 [∇]
000140	Profession labour force status of health professional, version 1
000141	Number of contacts (psychiatric outpatient clinic/day program), version 1
000141	Number of service contact dates, version 2 [∇]
000142	Reason for removal, version 2
000143	Referral to further care (psychiatric patients), version 1
000145	Resuscitation of baby, version 1
000146	Same-day patient (<i>concept</i>), version 1
000147	Scheduled admission date, version 2
000148	Separation (<i>concept</i>), version 1
000149	Sex, version 1
000150	Source of referral to public psychiatric hospital, version 3
000153	Specialised nursing requirements – at nursing home admission, version 1
000154	Specialised nursing requirements – current status, version 1
000155	State/Territory of birth, version 1
000159	Status of the baby, version 1
000160	Stillbirth (foetal death) (<i>concept</i>), version 1
000161	Surgical specialty, version 1
000163	Total leave days, version 3
000164	Total psychiatric care days, version 2
000166	Type and sector of employment establishment, version 1
000167	Type of augmentation of labour, version 1
000168	Type of episode of care, version 3
000171	Type of labour induction, version 1
000172	Type of nursing home admission, version 1
000173	Type of usual accommodation, version 1

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Knowledgebase ID no.	Data element name
000173	Type of accommodation, version 2 [∇]
000174	Census date, version 2
000176	Waiting list category, version 3
000204	Department of Veterans' Affairs file number, version 1
000205	Separations, version 2
000206	Patient days, version 2
000208	Patients in residence at year end, version 1
000209	Occasions of service, version 1
000210	Group sessions, version 1
000211	Day program attendances, version 1
000224	Administrative expenses, version 1
000230	Occupation of person, version 2 [∇]
000231	Type of non-admitted patient care, version 1
000232	Type of admitted patient care for same-day patients, version 3
000233	Type of non-admitted patient care (public psychiatric, alcohol and drug), version 1
000234	Type of non-admitted patient care (nursing homes and hostels), version 1
000235	Individual group session, version 1
000236	Payments to visiting medical officers, version 1
000237	Superannuation employer contributions (including funding basis), version 1
000238	Drug supplies, version 1
000239	Medical and surgical supplies, version 1
000240	Food supplies, version 1
000241	Domestic services, version 1
000242	Repairs and maintenance, version 1
000243	Patient transport, version 1
000245	Interest payments, version 1
000246	Depreciation, version 1
000247	Other recurrent expenditure, version 1
000248	Capital expenditure, version 1
000252	Full-time equivalent staff, version 2
000254	Salaries and wages, version 1
000255	Number of available beds for admitted patients, version 2
000295	Recoveries, version 1
000296	Patient revenue, version 1
000309	Dependency in activities of daily living, version 1
000313	Hours worked by health professional, version 2
000317	Employment status – public psychiatric hospital admissions, version 2
000321	Specialised service indicators, version 1
000322	Teaching status, version 1
000323	Other revenues, version 1
000325	Capital expenditure – gross (accrual accounting), version 2
000326	Indirect health care expenditure, version 1
000327	Establishment type, version 1
000342	Date of change to qualification status, version 1
000343	Qualification status, version 1

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Knowledgebase ID no.	Data element name
000344	Apgar score at 1 minute, version 1
000345	Apgar score at 5 minutes, version 1
000346	Number of acute (qualified)/unqualified days for newborns, version 1
000347	Emergency Department waiting time to service delivery, version 1
000348	Elective care (<i>concept</i>), version 1
000349	Patient presentation at Emergency Department (<i>concept</i>), version 1
000350	Date patient presents, version 1
000351	Time patient presents, version 1
000352	Type of visit, version 1
000353	Date of triage, version 1
000354	Time of triage, version 1
000355	Triage category, version 1
000356	Date of service event, version 1
000357	Time of service event, version 1
000358	Admission time, version 1
000359	Departure status, version 1
000360	Non-salary operating costs, version 1
000361	Adult height (<i>concept</i>), version 1
000362	Adult height – measured, version 1
000363	Adult height – self-reported, version 1
000364	Adult weight (<i>concept</i>), version 1
000365	Adult weight – measured, version 1
000366	Adult weight – self-reported, version 1
000367	Adult body mass index, version 1
000368	Adult body mass index – classification, version 1
000369	Adult hip circumference (<i>concept</i>), version 1
000370	Adult hip circumference – measured, version 1
000371	Adult abdominal circumference (<i>concept</i>), version 1
000372	Adult abdominal circumference – measured, version 1
000373	Adult abdomen to hip ratio, version 1
000374	Behaviour-related nursing requirements – at nursing home, current status, version 1
000375	Continence status (urine) of nursing home resident – at admission, version 2
000376	Continence status (urine) of nursing home resident – current status, version 2
000377	Establishment number, version 2
000378	Region code, version 2
000379	Establishment sector, version 2
000380	State identifier, version 2
000381	External cause – non-admitted patient, version 4
000383	Pension status – nursing home residents, version 2
000384	Place of occurrence of external cause of injury – admitted patient, version 4
000385	Mode of admission, version 4 [∇]
000387	Type of admitted patient care for overnight patients, version 3
000388	Type of admitted patient care for long-stay patients, version 3
000389	Type of admitted patient care for short-stay patients, version 3
000391	Category reassignment date, version 2

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Knowledgebase ID no.	Data element name
000392	Hours worked by medical practitioner in direct patient care, version 2
000393	Hours on-call (not worked) by medical practitioner, version 2
000394	Total hours worked by a medical practitioner, version 2
000395	Employment status – acute hospital and private psychiatric hospital admissions, version 2
000396	Capital expenditure – net (accrual accounting), version 2
000397	Emergency Department waiting time to admission, version 1
000398	Diagnosis (<i>concept</i>), version 1
000399	Clinical intervention (<i>concept</i>), version 1*
000400	Extended wait patient, version 1*
000401	Service contact (<i>concept</i>), version 1*
000402	Service contact date, version 1*
000403	Tobacco smoking – consumption/quantity (cigarettes), version 1*
000404	Tobacco smoking – duration (daily smoking), version 1*
000405	Tobacco smoking – ever daily use, version 1*
000406	Tobacco smoking – frequency, version 1*
000407	Tobacco smoking – product, version 1*
000408	Tobacco smoking – quit age (daily smoking), version 1*
000409	Tobacco smoking – status, version 1*
000410	Tobacco smoking – start age (daily smoking), version 1*
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000413	Waiting time at admission, version 1*

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