National Health Data Dictionary Version 13.3 Volume 2 Data elements Cr to Ful

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List of metadata items

Data Element Technical Names

Data Elements

Creatine kinase MB isoenzyme level (index code)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatine kinase myocardial band isoenzyme level (measured), index code X[XXX]
Synonymous names:	Creatine kinase MB isoenzyme (CK-MB) - measured
METeOR identifier:	284903
Registration status:	Health, Standard 04/06/2004
Definition:	A person's measured creatine kinase myocardial band (CK-MB) isoenzyme level, as represented by an index.
Data Element Concept:	Person—creatine kinase-myocardial band isoenzyme level

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	X[XXX]
Maximum character length:	4

Supplementary values:

Value	Meaning
9999	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

CODE 88888 if test for CK-MB was not done on this admission.

Measured in different units dependent upon laboratory methodology.

When only one CK-MB level is recorded, this should be the peak level during admission.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:

Supersedes Creatine kinase MB isoenzyme (CK-MB) - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.97 KB)

Supersedes Creatine kinase MB isoenzyme (CK-MB) - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.39 KB)

See also Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, index code X[XXX] Health, Standard 04/06/2004

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:
For Acute coronary syndrome (ACS) reporting, can be used to determine diagnostic strata.

Creatine kinase MB isoenzyme level (international units)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatine kinase-myocardial band isoenzyme level (measured), total international units N[NNN]
Synonymous names:	Creatine kinase MB isoenzyme (CK-MB) - measured
METeOR identifier:	284905
Registration status:	Health, Standard 04/06/2004
Definition:	A person's measured creatine kinase-myocardial band (CK-MB) isoenzyme level in international units.
Data Element Concept:	Person—creatine kinase-myocardial band isoenzyme level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
8888	Not measured
9999	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:

CODE 8888 if test for CK-MB was not done on this admission.

Measured in different units dependent upon laboratory methodology.

When only one CK-MB level is recorded, this should be the peak level during admission.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:

See also Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total international units N[NNN] Health, Standard 04/06/2004

Supersedes Creatine kinase MB isoenzyme (CK-MB) - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.39 KB)

Supersedes Creatine kinase MB isoenzyme (CK-MB) - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.97 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:
For Acute coronary syndrome (ACS) reporting, can be used to determine diagnostic strata.

Creatine kinase MB isoenzyme level (kCat per litre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatine kinase myocardial band isoenzyme level (measured), total kCat per litre N[NNN]
Synonymous names:	Creatine kinase MB isoenzyme (CK-MB) - measured
METeOR identifier:	284915
Registration status:	Health, Standard 04/06/2004
Definition:	A person's measured creatine kinase myocardial band (CK-MB) isoenzyme in kCat per litre.
Data Element Concept:	Person—creatine kinase-myocardial band isoenzyme level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
8888	Not measured
9999	Not stated/inadequately described

Proposed unit of measure:	kCat/L

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	CODE 8888 if test for CK-MB was not done on this admission. Measured in different units dependent upon laboratory methodology. When only one CK-MB level is recorded, this should be the peak level during admission.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	See also Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total kCat per litre N[NNN] Health, Standard 04/06/2004 Supersedes Creatine kinase MB isoenzyme (CK-MB) - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf

(13.97 KB)

Supersedes Creatine kinase MB isoenzyme (CK-MB) - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.39 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:
For Acute coronary syndrome (ACS) reporting, can be used to determine diagnostic strata.

Creatine kinase MB isoenzyme level (micrograms per litre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatine kinase-myocardial band isoenzyme level (measured), total micrograms per litre N[NNNN]
METeOR identifier:	284921
Registration status:	Health, Standard 04/06/2004
Definition:	A person's measured creatine kinase-myocardial band (CK-MB) isoenzyme level in micrograms per litre.
Data Element Concept:	Person—creatine kinase-myocardial band isoenzyme level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
9999	Not stated/inadequately described
8888	Not measured

Unit of measure: Microgram per litre (µg/L)

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:

CODE 8888 if test for CK-MB was not done on this admission.

Measured in different units dependent upon laboratory methodology.

When only one CK-MB level is recorded, this should be the peak level during admission.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:

Supersedes Creatine kinase MB isoenzyme (CK-MB) - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.39 KB)

Supersedes Creatine kinase MB isoenzyme (CK-MB) - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf

(13.97 KB)

See also Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total micrograms per litre N[NNN] Health, Standard 04/06/2004

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:
For Acute coronary syndrome (ACS) reporting, can be used to determine diagnostic strata.

Creatine kinase MB isoenzyme level (nanograms per decilitre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatine kinase myocardial band isoenzyme level (measured), total nanograms per decilitre N[NNN]
Synonymous names:	Creatine kinase MB isoenzyme (CK-MB) - measured
METeOR identifier:	284923
Registration status:	Health, Standard 04/06/2004
Definition:	A person's measured creatine kinase myocardial band (CK-MB) isoenzyme in nanograms per decilitre.
Data Element Concept:	Person—creatine kinase-myocardial band isoenzyme level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
8888	Not measured
9999	Not stated/inadequately described

Unit of measure: Nanogram per decilitre (ng/dl)

Data element attributes

Collection and usage attributes

Guide for use:

CODE 8888 if test for CK-MB was not done on this admission.

Measured in different units dependent upon laboratory methodology.

When only one CK-MB level is recorded, this should be the peak level during admission.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:

Supersedes Creatine kinase MB isoenzyme (CK-MB) - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.97 KB)

Supersedes Creatine kinase MB isoenzyme (CK-MB) - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.39 KB)

Implementation in Data Set Acute coronary syndrome (clinical) DSS Health, Superseded

Specifications:

07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:
For Acute coronary syndrome (ACS) reporting, can be used to determine diagnostic strata.

Creatine kinase MB isoenzyme level (percentage)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatine kinase myocardial band isoenzyme level (measured), percentage N[NNN]
Synonymous names:	Creatine kinase MB isoenzyme (CK-MB) - measured
METeOR identifier:	284913
Registration status:	Health, Standard 04/06/2004
Definition:	A person's measured creatine kinase myocardial band (CK-MB) isoenzyme as a percentage.
Data Element Concept:	Person—creatine kinase-myocardial band isoenzyme level

Value domain attributes

Representational attributes

Representation class:	Percentage
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
8888	Not measured
9999	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	CODE 8888 if test for CK-MB was not done on this admission. Measured in different units dependent upon laboratory methodology. When only one CK-MB level is recorded, this should be the peak level during admission.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:	Supersedes Creatine kinase MB isoenzyme (CK-MB) - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.97 KB) Supersedes Creatine kinase MB isoenzyme (CK-MB) - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.39 KB)

See also Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, percentage N[NNN] Health, Standard 04/06/2004

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:
For Acute coronary syndrome (ACS) reporting, can be used to determine diagnostic strata.

Creatine kinase MB isoenzyme—upper limit of normal range (index code)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, index code X[XXX]
Synonymous names:	Creatine kinase MB isoenzyme (CK-MB) - units
METeOR identifier:	284931
Registration status:	Health, Standard 04/06/2004
Definition:	Laboratory standard for the value of creatine kinase myocardial band (CK-MB) isoenzyme measured as an index that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	X[XXX]
Maximum character length:	4

Supplementary values:

Value	Meaning
9999	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the creatine kinase myocardial band (CK-MB) normal reference range for the testing laboratory.

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Creatine kinase MB isoenzyme (CK-MB) - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.87 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Creatine kinase MB isoenzyme—upper limit of normal range (international units)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total international units N[NNN]
METeOR identifier:	284959
Registration status:	Health, Standard 04/06/2004
Definition:	Laboratory standard for the value of creatine kinase myocardial band (CK-MB) isoenzyme measured in international units (IU) that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
8888	Not measured
9999	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the creatine kinase myocardial band (CK-MB) normal reference range for the testing laboratory.

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Creatine kinase MB isoenzyme (CK-MB) - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.87 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Creatine kinase MB isoenzyme—upper limit of normal range (kCat per litre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total kCat per litre N[NNN]
METeOR identifier:	284963
Registration status:	Health, Standard 04/06/2004
Definition:	Laboratory standard for the value of creatine kinase myocardial band (CK-MB) isoenzyme in kCat per litre that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
8888	Not measured
9999	Not stated/inadequately described

Proposed unit of measure:	kCat/L

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the creatine kinase myocardial band (CK-MB) normal reference range for the testing laboratory.

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Creatine kinase MB isoenzyme (CK-MB) - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.87 KB)
Implementation in Data Set	Acute coronary syndrome (clinical) DSS Health, Superseded

Specifications:	07/12/2005 Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Creatine kinase MB isoenzyme—upper limit of normal range (micrograms per litre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total micrograms per litre N[NNN]
METeOR identifier:	284965
Registration status:	Health, Standard 04/06/2004
Definition:	Laboratory standard for the value of creatine kinase myocardial band (CK-MB) isoenzyme measured in microgram per litre that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
9999	Not stated/inadequately described
8888	Not measured

Unit of measure: Microgram per litre (µg/L)

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: Record the upper limit of the creatine kinase myocardial band (CK-MB) normal reference range for the testing laboratory.

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Creatine kinase MB isoenzyme (CK-MB) - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.87 KB)
Implementation in Data Set	Acute coronary syndrome (clinical) DSS Health, Superseded

Specifications:	07/12/2005 Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Creatine kinase MB isoenzyme—upper limit of normal range (nanograms per decilitre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total nanograms per decilitre N[NNN]
METeOR identifier:	285957
Registration status:	Health, Standard 04/06/2004
Definition:	Laboratory standard for the value of creatine kinase myocardial band (CK-MB) isoenzyme measured in nanograms per decilitre that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
8888	Not measured
9999	Not stated/inadequately described

Unit of measure: Nanogram per decilitre (ng/dl)

Data element attributes

Collection and usage attributes

Guide for use: Record the upper limit of the creatine kinase myocardial band (CK-MB) normal reference range for the testing laboratory.

Source and reference attributes

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

Relational attributes

Related metadata references: Supersedes Creatine kinase MB isoenzyme (CK-MB) - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.87 KB)

Supersedes Creatine kinase MB isoenzyme (CK-MB) - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.97 KB)

Implementation in Data Set Acute coronary syndrome (clinical) DSS Health, Superseded

Specifications:	07/12/2005 Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Creatine kinase MB isoenzyme—upper limit of normal range (percentage)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, percentage N[NNN]
METeOR identifier:	284961
Registration status:	Health, Standard 04/06/2004
Definition:	Laboratory standard for the value of creatine kinase myocardial band (CK-MB) isoenzyme measured as a percentage that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme

Value domain attributes

Representational attributes

Representation class:	Percentage
Data type:	Number
Format:	N[NNN]
Maximum character length:	4

Supplementary values:

Value	Meaning
8888	Not measured
9999	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the creatine kinase myocardial band (CK-MB) normal reference range for the testing laboratory.

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Creatine kinase MB isoenzyme (CK-MB) - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.87 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Creatinine serum level (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatinine serum level, micromoles per litre NN[NN]
METeOR identifier:	270392
Registration status:	Health, Standard 01/03/2005
Definition:	A person's serum creatinine level measured in micromoles per litre (µmol/L).
Data Element Concept:	Person—creatinine serum level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	String
Format:	NN[NN]
Maximum character length:	4
Unit of measure:	Micromole per litre (µmol/L)

Data element attributes

Collection and usage attributes

Guide for use:

There is no agreed standard as to which units serum creatinine should be recorded in.

Note: If the measurement is obtained in mmol/L it is to be multiplied by 1000.

Collection methods:

Measurement of creatinine should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.

- Single venous blood test taken at the time of other screening blood tests.
- Fasting not required.

Comments:

Serum creatinine can be used to help determine renal function. Serum creatinine by itself is an insensitive measure of renal function because it does not increase until more than 50% of renal function has been lost.

Serum creatinine together with a patient's age, weight and sex can be used to calculate glomerular filtration rate (GFR), which is an indicator of renal status/ function. The calculation uses the Cockcroft-Gault formula.

Creatinine is normally produced in fairly constant amounts in the muscles, as a result the breakdown of phosphocreatine. It passes into the blood and is excreted in the urine. Serum creatinine can be used to help determine renal function. The elevation in the creatinine level in the blood indicates disturbance in kidney function.

GFR decreases with age, but serum creatinine remains relatively stable. When serum creatinine is measured, renal

function in the elderly tends to be overestimated, and GFR should be used to assess renal function, according to the Cockcroft-Gault formula:

GFR (ml/min) = (140 - age [yrs]) x body wt (kg) [x 0.85 (for women)]
814 x serum creatinine (mmol/l)

To determine chronic renal impairment

GFR > 90ml/min - normal

GFR >60 - 90ml/min - mild renal impairment

GFR >30 - 60ml/min - moderate renal impairment

GFR 0 - 30 ml/min - severe renal impairment

Note: The above GFR measurement should be for a period greater than 3 months. GFR may also be assessed by 24-hour creatinine clearance adjusted for body surface area.

In general, patients with GFR < 30 ml/min are at high risk of progressive deterioration in renal function and should be referred to a nephrology service for specialist management of renal failure.

Patients should be assessed for the complications of chronic renal impairment including anaemia, hyperparathyroidism and be referred for specialist management if required.

Patients with rapidly declining renal function or clinical features to suggest that residual renal function may decline rapidly (ie. hypertensive, proteinuric (>1g/24hours), significant comorbid illness) should be considered for referral to a nephrologist well before function declines to less than 30ml/min. (Draft CARI Guidelines 2002. Australian Kidney Foundation). Patients in whom the cause of renal impairment is uncertain should be referred to a nephrologist for assessment.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

National Diabetes Data Working Group

Origin: Caring for Australians with Renal Impairment (CARI) Guidelines. Australian Kidney Foundation

Relational attributes

Related metadata references: Supersedes Creatinine serum - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.73 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

In settings where the monitoring of a person's health is ongoing and where a measure can change over time (such as general practice), the Service contact—service contact date, DDMMYYYY should be recorded.

Record absolute result of the most recent serum creatinine measurement in the last 12 months to the nearest µmol/L (micromoles per litre).

Cardiovascular disease (clinical) DSS Health, Superseded

15/02/2006

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

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

Information specific to this data set:

In settings where the monitoring of a person's health is ongoing and where a measure can change over time (such as general practice), the Service contact—service contact date, DDMMYYYY should be recorded.

Record absolute result of the most recent serum creatinine measurement in the last 12 months to the nearest µmol/L (micromoles per litre).

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

In settings where the monitoring of a person's health is ongoing and where a measure can change over time (such as general practice), the Service contact—service contact date, DDMMYYYY should be recorded.

Record absolute result of the most recent serum creatinine measurement in the last 12 months to the nearest µmol/L (micromoles per litre).

Date accuracy indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Date—accuracy indicator, code AAA
METeOR identifier:	294429
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	An indicator of the accuracy of the components of a reported date, as represented by a code.
Data Element Concept:	Date—accuracy indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	AAA
Maximum character length:	3

Permissible values:

Value	Meaning
AAA	Day, month and year are accurate
AAE	Day and month are accurate, year is estimated
AAU	Day and month are accurate, year is unknown
AEE	Day is accurate, month and year are estimated
AEU	Day is accurate, month is estimated, year is unknown
AUU	Day is accurate, month and year are unknown
AUA	Day is accurate, month is unknown, year is accurate
AUE	Day is accurate, month is unknown, year is estimated
AEA	Day is accurate, month is estimated, year is accurate
EAA	Day is estimated, month and year are accurate
EAE	Day is estimated, month is accurate, year is estimated
EAU	Day is estimated, month is accurate, year is unknown
EEA	Day and month are estimated, year is accurate
EEE	Day, month and year are estimated
EEU	Day and month are estimated, year is unknown
EUA	Day is estimated, month is unknown, year is accurate
EUE	Day is estimated, month is unknown, year is estimated
EUU	Day is estimated, month and year are unknown

UAA	Day is unknown, month and year are accurate
UAE	Day is unknown, month is accurate, year is estimated
UAU	Day is unknown, month is accurate, year is unknown
UEA	Day is unknown, month is estimated, year is accurate
UEE	Day is unknown, month and year are estimated
UEU	Day is unknown, month is estimated, year is unknown
UUA	Day and month are unknown, year is accurate
UUE	Day and month are unknown, year is estimated
UUU	Day, month and year are unknown

Collection and usage attributes

Guide for use:

Any combination of the values A, E, U representing the corresponding level of accuracy of each date component of the reported date.

This data element consists of a combination of three codes, each of which denotes the accuracy of one date component:

A – the referred date component is accurate

E – the referred date component is not known but is estimated

U – the referred date component is not known and not estimated.

This data element contains positional fields (DMY) that reflects the order of the date components in the format (DDMMYYYY) of the reported date:

field 1 (D) – refers to the accuracy of the day component

field 2 (M) – refers to the accuracy of the month component

field 3 (Y) – refers to the accuracy of the year component.

Data domain	Date component (for a format DDMMYYYY)		
	(D)ay	(M)onth	(Y)ear
Accurate	A	A	A
Estimated	E	E	E
Unknown	U	U	U

This data element is valid only for use with dates that are reported/exchanged in the format (DDMMYYYY).

Example 1: A date has been sourced from a reliable source and is known as accurate then the Date accuracy indicator should be informed as (AAA).

Example 2: If only the age of the person is known and there is no certainty of the accuracy of this, then the Date accuracy indicator should be informed as (UUE). That is the day and month are “unknown” and the year is “estimated”.

Example 3: If a person was brought in unconscious to an emergency department of a hospital and the only information available was from a relative who was certain of the age and the birthday’s 'month' then the Date accuracy indicator should be informed as (UAA). A year derived from an accurate month

and accurate age is always an accurate year.

The Date accuracy indicator can be useful for operational purposes to indicate the level of accuracy that a date has been collected at any point in time. It can indicate whether the stored date needs to be followed up until it reaches the intended minimal required accuracy. For example, if a person was brought in unconscious to an emergency department of a hospital the level of accuracy of the date collected at that point may not be satisfactory. It is likely that the correct date of birth can be obtained at a later date. The Date accuracy indicator provides information on the accuracy of the entered dates that may require further action.

For future users of the data it may also be essential they know the accuracy of the date components of a reported date.

Data element attributes

Collection and usage attributes

Collection methods:

Collection constraints:

If constraints for the collection of the date are imposed, such as 'a valid date must be input in an information system for unknown date components', the Date accuracy indicator should be used along with the date as a way of avoiding the contamination of the valid dates with the same value on the respective date components.

Example:

Some jurisdictions use 0107YYYY and some use 0101YYYY when only the year is known. When month and year are known some use the 15th day as the date i.e. 15MMYYYY. Where this occurs in a data collection that is used for reporting or analysis purposes there will be dates in the collection with the attributes 0107YYYY etc that are accurate and some that are not accurate. Without a corresponding flag to determine this accuracy the analysis or report will be contaminated by those estimated dates.

Comments:

Provision of a date is often a mandatory requirement in data collections.

Most computer systems require a valid date to be recorded in a date field i.e. the month part must be an integer between 1 and 12, the day part must be an integer between 1 and 31 with rules about the months with less than 31 days, and the year part should include the century. Also in many systems, significant dates (e.g. date of birth) are mandatory requirements.

However, in actual practice, the date or date components are often not known (e.g. date of birth, date of injury) but, as stated above, computer systems require a valid date. This means that a date MUST be included and it MUST follow the rules for a valid date. It therefore follows that, while such a date will contain valid values according to the rules for a date, the date is in fact an 'unknown' or 'estimated' date. For future users of the data it is essential they know that a date is accurate, unknown or estimated and which components of the date are accurate, unknown or estimated.

Source and reference attributes

Submitting organisation: Standards Australia

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

Relational attributes

Related metadata references:

See also Service provider organisation—organisation end date, DDMMYYYY Health, Standard 04/05/2005, Community services, Standard 30/09/2005

See also Service provider organisation—organisation start date, DDMMYYYY Health, Standard 04/05/2005, Community services, Standard 30/09/2005

See also Person—date of birth, DDMMYYYY Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 20/06/2005

See also Individual service provider—occupation start date, DDMMYYYY Health, Standard 04/05/2005, Community services, Standard 30/09/2005

See also Individual service provider—occupation end date, DDMMYYYY Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Implementation in Data Set Specifications:

Health care client identification DSS Health, Standard 04/05/2005

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

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

Date creatine kinase MB isoenzyme measured

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—creatine kinase myocardial band isoenzyme measured date, DDMMYYYY
METeOR identifier:	284973
Registration status:	Health, Standard 04/06/2004
Definition:	The date on which the person's creatine kinase myocardial band isoenzyme (CK-MB) is measured.
Data Element Concept:	Person—creatine kinase myocardial band isoenzyme measured date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item pertains to the measuring of creatine kinase myocardial band (CK-MB) isoenzyme at any time point during this current event.

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Date creatine kinase MB isoenzyme (CK-MB) measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.71 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Date of birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—date of birth, DDMMYYYY
METeOR identifier:	287007
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 20/06/2005
Definition:	The date of birth of the person.
Data Element Concept:	Person—date of birth

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	If date of birth is not known or cannot be obtained, provision should be made to collect or estimate age. Collected or estimated age would usually be in years for adults, and to the nearest three months (or less) for children aged less than two years. Additionally, an estimated date flag or a date accuracy indicator should be reported in conjunction with all estimated dates of birth. For data collections concerned with children's services, it is suggested that the estimated date of birth of children aged under 2 years should be reported to the nearest 3 month period, i.e. 0101, 0104, 0107, 0110 of the estimated year of birth. For example, a child who is thought to be aged 18 months in October of one year would have his/her estimated date of birth reported as 0104 of the previous year. Again, an estimated date flag or date accuracy indicator should be reported in conjunction with all estimated dates of birth.
Collection methods:	Information on date of birth can be collected using the one question: What is your/(the person's) date of birth? In self-reported data collections, it is recommended that the following response format is used: Date of birth: _ _ / _ _ / _ _ _ _ This enables easy conversion to the preferred representational layout (DDMMYYYY). For record identification and/or the derivation of other metadata items that require accurate date of birth information, estimated dates of birth should be identified by a date accuracy indicator to prevent inappropriate use of date of birth data . The

linking of client records from diverse sources, the sharing of patient data, and data analysis for research and planning all rely heavily on the accuracy and integrity of the collected data. In order to maintain data integrity and the greatest possible accuracy an indication of the accuracy of the date collected is critical. The collection of an indicator of the accuracy of the date may be essential in confirming or refuting the positive identification of a person. For this reason it is strongly recommended that the data element Date—accuracy indicator, code AAA also be recorded at the time of record creation to flag the accuracy of the data.

Comments:

Privacy issues need to be taken into account in asking persons their date of birth.

Wherever possible and wherever appropriate, date of birth should be used rather than age because the actual date of birth allows a more precise calculation of age.

When date of birth is an estimated or default value, national health and community services collections typically use 0101 or 0107 or 3006 as the estimate or default for DDMM.

It is suggested that different rules for reporting data may apply when estimating the date of birth of children aged under 2 years because of the rapid growth and development of children within this age group which means that a child's development can vary considerably over the course of a year. Thus, more specific reporting of estimated age is suggested.

Source and reference attributes

Origin:

National Health Data Committee

National Community Services Data Committee

Reference documents:

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

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

Relational attributes

Related metadata references:

See also Date—accuracy indicator, code AAA Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Supersedes Person—date of birth, DDMMYYYY Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN Health, Standard 01/03/2005

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

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

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA Health, Standard 01/03/2005

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

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

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:
This field must not be null.

National Minimum Data Sets:

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

- be less than or equal to Admission date, Date patient presents or Service contact date
- be consistent with diagnoses and procedure codes, for records to be grouped.

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

This field must not be null.

National Minimum Data Sets:

For the provision of State and Territory hospital data to

Commonwealth agencies this field must:

- be less than or equal to Admission date, Date patient presents or Service contact date
- be consistent with diagnoses and procedure codes, for records to be grouped.

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient palliative care NMDS 2008-09 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

This field must not be null.

National Minimum Data Sets:

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

- be less than or equal to Admission date, Date patient presents or Service contact date
- be consistent with diagnoses and procedure codes, for records to be grouped.

Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

This field must not be null.

National Minimum Data Sets:

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

- be less than or equal to Admission date, Date patient presents or Service contact date
- be consistent with diagnoses and procedure codes, for records to be grouped.

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

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

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

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

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

Community mental health care 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

This field must not be null.

National Minimum Data Sets:

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

- be less than or equal to Admission date, Date patient presents or Service contact date
- be consistent with diagnoses and procedure codes, for records to be grouped.

Computer Assisted Telephone Interview demographic module DSS Health, Standard 04/05/2005

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Health care client identification DSS Health, Standard 04/05/2005

Information specific to this data set:

Date of birth must be less than of equal to the date of death.

Health care provider identification DSS Health, Superseded

04/07/2007

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

Information specific to this data set:
Date of birth must be less than or equal to the date of death.

Health labour force NMDS Health, Standard 01/03/2005

Implementation start date: 01/07/2005

Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

This field must not be null.

National Minimum Data Sets:

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

- be less than or equal to Admission date, Date patient presents or Service contact date
- be consistent with diagnoses and procedure codes, for records to be grouped.

Perinatal NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

This field must not be null.

National Minimum Data Sets:

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

- be less than or equal to Admission date, Date patient presents or Service contact date
- be consistent with diagnoses and procedure codes, for records to be grouped.

Date of cessation of treatment episode for alcohol and other drugs

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—treatment cessation date, DDMMYYYY
METeOR identifier:	270067
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a treatment episode for alcohol and other drugs ceases.
Data Element Concept:	Episode of treatment for alcohol and other drugs—treatment cessation date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	Refers to the date of the last service contact in a treatment episode between the client and staff of the treatment provider. In situations where the client has had no contact with the treatment provider for three months, nor is there a plan in place for further contact, the date of last service contact should be used. Refer to the glossary item **Cessation of treatment episode for alcohol and other drugs** to determine when a treatment episode ceases. The date must be later than or the same as the treatment commencement date for the episode of treatment for alcohol and other drugs.
Comments:	Required to identify the cessation of a treatment episode by an alcohol and other drug treatment service.

Source and reference attributes

Submitting organisation:	Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references:	Supersedes Date of cessation of treatment episode for alcohol and other drugs, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.63 KB)
Implementation in Data Set Specifications:	Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

The date must be later than or the same as the treatment commencement date for the episode of treatment for alcohol and other drugs.

Date of change to qualification status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care (newborn)—date of change to qualification status, DDMMYYYY
METeOR identifier:	270034
Registration status:	Health, Standard 01/03/2005
Definition:	The date, within a newborn episode of care, on which the newborn's **Qualification status** changes from acute (qualified) to unqualified or vice versa.
Data Element Concept:	Episode of admitted patient care (newborn)—date of change to qualification status

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	Record the date or dates on which the newborn's **Qualification status** changes from acute (qualified) to unqualified or vice versa. If more than one change of qualification status occurs on a single day, the day is counted against the final qualification status. Must be greater than or equal to admission date.

Relational attributes

Related metadata references:	Supersedes Date of change to qualification status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.88 KB) Is used in the formation of Episode of admitted patient care (newborn)—number of qualified days, total N[NNNN] Health, Standard 01/03/2005

Date of commencement of treatment episode for alcohol and other drugs

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—treatment commencement date, DDMMYYYY
METeOR identifier:	270069
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which the first service contact within the treatment episode when assessment and/or treatment occurs.
Data Element Concept:	Episode of treatment for alcohol and other drugs—treatment commencement date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

A client is identified as commencing a treatment episode if one or more of the following apply:

- they are a new client,
- they are a client recommencing treatment after they have had had no contact with the treatment provider for a period of three months or had any plan in place for further contact,
- their principal drug of concern for alcohol and other drugs has changed,
- their main treatment type for alcohol and other drugs has changed,
- their treatment delivery setting for alcohol and other drugs has changed.

Comments:

Required to identify the commencement of a treatment episode by an alcohol and other drug treatment service.

Source and reference attributes

Submitting organisation:	Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references:

Supersedes Date of commencement of treatment episode for alcohol and other drugs, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.07 KB)

Supersedes Commencement of treatment episode for alcohol

and other drugs, version 2, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.48 KB)

Implementation in Data Set Specifications:

Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

The date must be earlier than or the same as the treatment cessation date for the episode of treatment for alcohol and other drugs.

Date of completion of last previous pregnancy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Pregnancy (last previous)—pregnancy completion date, DDMMYYYY
METeOR identifier:	270002
Registration status:	Health, Standard 01/03/2005
Definition:	Date on which the pregnancy preceding the current pregnancy was completed.
Data Element Concept:	Pregnancy (last previous)—pregnancy completion date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	Estimate day of month (DD), if first day is unknown.
Comments:	This metadata item is recommended by the World Health Organization. It is currently collected in some states and territories. Interval between pregnancies may be an important risk factor for the outcome of the current pregnancy, especially for preterm birth and low **birthweight**.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Date of completion of last previous pregnancy, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.62 KB)

Date of death

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—date of death, DDMMYYYY
METeOR identifier:	287305
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The date of death of the person.
Data Element Concept:	Person—date of death

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	Recorded for persons who have died. Where Date of birth is collected, Date of death must be equal to or greater than Date of birth for the same person.
Collection methods:	It is recommended that in cases where all components of the date of death are not known or where an estimate is arrived at from age, a valid date be used together with a flag to indicate that it is an estimate. For record identification and/or the derivation of other metadata items that require accurate date of death information, estimated dates of death should be identified by a date accuracy indicator to prevent inappropriate use of date of death data . The linking of client records from diverse sources, the sharing of patient data, and data analysis for research and planning all rely heavily on the accuracy and integrity of the collected data. In order to maintain data integrity and the greatest possible accuracy an indication of the accuracy of the date collected is critical. The collection of Date accuracy indicator may be essential in confirming or refuting the positive identification of a person. For this reason it is strongly recommended that the data element Date accuracy indicator also be recorded at the time of record creation to flag the accuracy of the data.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Health Data Standards Committee

Relational attributes

Related metadata references:	Supersedes Date of death, version 1, DE, NHDD, NHIMG,

Superseded 01/03/2005.pdf (13.54 KB)

Implementation in Data Set Specifications:

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

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

Information specific to this data set:
This field must be greater than or equal to Date of diagnosis of primary cancer.

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

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

Date of diagnosis

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—diagnosis date, DDMMYYYY
METeOR identifier:	270544
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a patient is diagnosed with a particular condition or disease.
Data Element Concept:	Patient—diagnosis date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Comments:	Classification systems, which enable the allocation of a code to the diagnostic information, can be used in conjunction with this metadata item.

Source and reference attributes

Submitting organisation:	Cardiovascular Data Working Group

Relational attributes

Related metadata references:	Supersedes Date of diagnosis, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (13.89 KB)
Implementation in Data Set Specifications:	Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006 Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007 Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Date of diagnosis of cancer

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—diagnosis date (cancer), DDMMYYYY
METeOR identifier:	270061
Registration status:	Health, Standard 01/03/2005
Definition:	The date when the cancer was first diagnosed (whether at its primary site or as a metastasis).
Context:	Patient administration system, cancer notification system, population cancer statistics, research.
Data Element Concept:	Patient—diagnosis date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	Date of diagnosis must be: >= date of birth <= date of death Diagnosis of cancer after death: If the patient is first diagnosed with the cancer in an autopsy report the date of diagnosis is the date of death as stated on the patient's death certificate. Incidental diagnosis of cancer: If a patient is admitted for another condition (for example a broken leg or pregnancy), and a cancer is diagnosed incidentally then the date of diagnosis is the date the cancer was diagnostically determined, not the admission date.
Collection methods:	Reporting rules: The date of diagnosis is the date of the pathology report, if any, that first confirmed the diagnosis of cancer. This date may be found attached to a letter of referral or a patient's medical record from another institution or hospital. If this date is unavailable, or if no pathological test was done, then the date may be determined from one of the sources listed in the following sequence: Date of the consultation at, or admission to, the hospital, clinic or institution when the cancer was first diagnosed. Note: DO NOT use the admission date of the current admission if the patient had a prior diagnosis of this cancer. Date of first diagnosis as stated by a recognised medical practitioner or dentist. Note: This date may be found attached

to a letter of referral or a patient's medical record from an institution or hospital.

Date the patient states they were first diagnosed with cancer. Note: This may be the only date available in a few cases (for example, patient was first diagnosed in a foreign country).

If components of the date are not known, an estimate should be provided where possible with an estimated date flag to indicate that it is estimated. If an estimated date is not possible, a standard date of 15 June 1900 should be used with a flag to indicate the date is not known.

Source and reference attributes

Origin:

International agency for research on cancer

World Health Organisation

International Association of Cancer Registries

Reference documents:

Modified from the definition presented by the New South Wales Inpatient Statistics Collection Manual 2000/2001

Relational attributes

Related metadata references:

Supersedes Date of diagnosis of cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.35 KB)

Implementation in Data Set Specifications:

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

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

Date of diagnosis of first recurrence

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—diagnosis date (first recurrence of cancer), DDMMYYYY
METeOR identifier:	288596
Registration status:	Health, Standard 04/06/2004
Definition:	The date a medical practitioner confirms the diagnosis of a recurrent or metastatic cancer of the same histology.
Data Element Concept:	Patient—diagnosis date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	The term `recurrence' defines the return, reappearance or metastasis of cancer (of the same histology) after a disease free period.
Comments:	This item is collected for determining the time interval from diagnosis to recurrence, from treatment to recurrence and from recurrence to death.

Source and reference attributes

Origin:	Commission on Cancer, American College of Surgeons
Reference documents:	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:	Supersedes Date of diagnosis of first recurrence, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.85 KB)
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Standard 07/12/2005 *Information specific to this data set:* This field must: • be greater than the date of diagnosis of cancer • be greater than the cancer initial treatment - completion date (if less than cancer initial treatment - completion date, the patient was never disease-free)

Date of first angioplasty balloon inflation or stenting

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—first angioplasty balloon inflation or stenting date, DDMMYYYY
METeOR identifier:	284979
Registration status:	Health, Standard 04/06/2004
Definition:	Date of the first angioplasty balloon inflation or stent placement.
Data Element Concept:	Person—first angioplasty balloon inflation or stenting date

Value domain attributes

Representational attributes

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

Data element attributes

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Date of first angioplasty balloon inflation or stenting, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.95 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005 *Information specific to this data set:* For Acute Coronary Syndrome (ACS) reporting, refers to the date of first angioplasty balloon inflation or coronary stenting for this admission.

Date of first contact

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Community nursing service episode—first contact date, DDMMYYYY
METeOR identifier:	270190
Registration status:	Health, Standard 01/03/2005
Definition:	The date of first contact with the community nursing service for an episode of care, between a staff member and a person or a person's family.
Data Element Concept:	Community nursing service episode—first contact date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

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

Includes:

- visits made to a person in institutional settings such as liaison visits or discharge planning visits, made in a hospital or residential aged care service with the intent of planning for the future delivery of service at home;
- telephone contacts when these are in lieu of a first home or hospital visit for the purpose of preliminary assessment for care at home;
- visits made to the person's home prior to admission for the purpose of assessing the suitability of the home environment for the person's care.

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

Excludes:

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

Collection methods:

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

Comments:

This metadata item is recommended for use in community services which are funded for liaison or discharge planning positions or provide specialist consultancy or assessment

services. Further developments in community care, including casemix and coordinated care will require collection of data relating to resource expenditure across the sector.

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

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Relational attributes

Related metadata references: Supersedes Date of first contact, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.92 KB)

Date of first delivery of service

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care (community setting)—first service delivery date, DDMMYYYY
METeOR identifier:	270210
Registration status:	Health, Standard 01/03/2005
Definition:	The date of first delivery of service to a person in a non-institutional setting.
Data Element Concept:	Episode of care—first service delivery date (community setting)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	This date may occur on the same day or prior to the Date of last delivery of service, but must never occur after that date within the current episode of care. The date may be the same as the Community nursing service episode—first contact date, DDMMYYYY.
Collection methods:	As long as contact is made with the person in a non-institutional setting, the Episode of care (community setting)—first service delivery date, DDMMYYYY must be recorded. Normally this will be the first home or clinic visit and is the date most often referred to in a service agency as the admission. This date applies whether a person is being admitted for the first time, or is being re-admitted for care.
Comments:	This metadata item is used for the analysis of time periods within a care episode and to locate that episode in time. The date relates to the first delivery of formal services within the community setting. This date marks the most standard event, which occurs at the beginning of an episode of care in community setting. It should not be confused with the Date of first contact with a community nursing service; although they could be the same, the dates for both items must be recorded. Agencies providing **hospital-in-the-home** services should develop their own method of distinguishing between the period the person remains a formal patient of the hospital, with funding to receive services at home, and the discharge of the person into the care of the community service.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Relational attributes

Related metadata references: Supersedes Date of first delivery of service, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.22 KB)

Date of intravenous fibrinolytic therapy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—intravenous fibrinolytic therapy date, DDMMYYYY
METeOR identifier:	284985
Registration status:	Health, Standard 04/06/2004
Definition:	The date intravenous (IV) fibrinolytic therapy was administered or initiated.
Data Element Concept:	Person—intravenous fibrinolytic therapy date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	If initiated by a bolus dose whether in a pre-hospital setting, emergency department or inpatient unit/ward, the date the initial bolus was administered should be reported.

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Date of intravenous fibrinolytic therapy, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.82 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005 *Information specific to this data set:* For Acute coronary syndrome (ACS) reporting, refers to coronary arteries.

Date of last contact

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Community nursing service episode—last contact date, DDMMYYYY
METeOR identifier:	270191
Registration status:	Health, Standard 01/03/2005
Definition:	Date of the last contact between a staff member of the community service and a person in any setting.
Data Element Concept:	Community nursing service episode—last contact date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

This could be the same as the date of discharge.

Includes:

- visits made to persons in institutional settings for the purpose of handing over or otherwise completing a care episode;
- bereavement visits in any setting;
- visits made to the person's home to complete the service, including the collection of equipment.

Excludes:

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

Comments:

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

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

Source and reference attributes

Submitting organisation:	Australian Council of Community Nursing Services

Relational attributes

Related metadata references:	Supersedes Date of last contact, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.11 KB)

Date of procedure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care (procedure)—procedure commencement date, DDMMYYYY
METeOR identifier:	270298
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a procedure commenced during an inpatient episode of care.
Data Element Concept:	Episode of admitted patient care (procedure)—procedure commencement date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	Admitted patients: Record date of procedure for all procedures undertaken during an episode of care in accordance with the current edition of ICD-10-AM.
Collection methods:	Date of procedure >= admission date Date of procedure <= separation date
Comments:	The National Centre for Classification in Health advises the Health Data Standards Committee of relevant changes to the ICD-10-AM. Required to provide information on the timing of the procedure in relation to the episode of care.

Source and reference attributes

Origin:	National Centre for Classification in Health National Health Data Committee
Reference documents:	Australian Institute of Health and Welfare (AIHW) 2000. Australian hospital statistics 1998-1999. AIHW cat. no. HSE 11. Canberra: AIHW (Health Services Series no. 15)

Relational attributes

Related metadata references:	Supersedes Date of procedure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.14 KB)

Date of referral to rehabilitation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health service event—referral to rehabilitation service date, DDMMYYYY
METeOR identifier:	269993
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a person is referred to a rehabilitation service.
Data Element Concept:	Health service event—referral to rehabilitation service date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	If date of referral is not known then provision should be made to collect month and year as a minimum, using 01 as DD (as the date part) if only the month and year are known.
Collection methods:	To be collected at the time of commencement of rehabilitation.

Source and reference attributes

Submitting organisation:	Cardiovascular Data Working Group

Relational attributes

Related metadata references:	Supersedes Date of referral to rehabilitation, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.17 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005 *Information specific to this data set:* Required to derive those referred to a rehabilitation service from those eligible to attend and who actually attend. This metadata item can be used to determine the time lag between referral and commencement of rehabilitation. Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006 Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007 Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Date of surgical treatment for cancer

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—surgical procedure date, DDMMYYYY
METeOR identifier:	288632
Registration status:	Health, Standard 04/06/2004
Definition:	The date on which the cancer-directed surgical treatment was performed.
Data Element Concept:	Cancer treatment—surgical procedure date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	The date of each surgical treatment episode should be entered separately. Collected for curative and palliative surgery prior to the first recurrence.

Source and reference attributes

Submitting organisation:	National Cancer Control Initiative
Origin:	Commission on Cancer, American College of Surgeons
Reference documents:	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:	Supersedes Date of surgical treatment for cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.47 KB)
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Standard 07/12/2005 *Information specific to this data set:* This field must be greater than or equal to the date of initial cancer diagnosis. This item is collected for analyses of outcome by treatment type.

Date of triage

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—triage date, DDMMYYYY
METeOR identifier:	313815
Registration status:	Health, Standard 07/12/2005
Definition:	The date on which the patient is **triaged**.
Data Element Concept:	Non-admitted patient emergency department service episode—triage date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Collection methods:	Collected in conjunction with non-admitted patient emergency department service episode—**triage** time.

Source and reference attributes

Submitting organisation:	Australian Government Department of Health and Ageing

Relational attributes

Related metadata references:	Supersedes Triage—triage date, DDMMYYYY Health, Superseded 07/12/2005
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005 Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008 *Implementation start date:* 01/07/2007 *Implementation end date:* 30/06/2008 Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008

Date patient presents

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health service event—presentation date, DDMMYYYY
METeOR identifier:	270393
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which the patient/client presents for the delivery of a service.
Data Element Concept:	Health service event—presentation date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

For community health care, outreach services and services provided via telephone or telehealth, this may be the date on which the service provider presents to the patient or the telephone/telehealth session commences.

The date of patient presentation at the **Emergency department** is the earliest occasion of being registered clerically or triaged.

The date that the patient presents is not necessarily:

- the listing date for care (see listing date for care), nor
- the date on which care is scheduled to be provided, nor
- the date on which commencement of care actually occurs (for admitted patients see admission date, for hospital non-admitted patient care and community health care see service commencement date).

Source and reference attributes

Submitting organisation:	National Institution Based Ambulatory Model Reference Group
Origin:	National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Date patient presents, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.32 KB)

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

Is used in the formation of Non-admitted patient emergency department service episode—service episode length, total minutes NNNNN Health, Standard 01/03/2005

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

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Date troponin measured

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—troponin level measured date, DDMMYYYY
METeOR identifier:	285021
Registration status:	Health, Standard 04/06/2004
Definition:	Date the person's troponin assay is measured.
Data Element Concept:	Person—troponin level measured date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item pertains to the measuring of troponin at any time point during this current event.

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Date troponin measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.45 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Day program attendances

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of day centre attendances, total N[NNNN]
METeOR identifier:	270245
Registration status:	Health, Standard 01/03/2005
Definition:	A count of the number of patient/client visits to day centres.
Data Element Concept:	Establishment—number of day centre attendances

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNN]
Maximum character length:	5
Unit of measure:	Attendance

Data element attributes

Collection and usage attributes

Comments:	This metadata item is derived from components that are not currently specified in METeOR, but which are recorded in various ways by hospitals and/or outpatient departments. Examples include identifiers of individual consultations/visits, diagnostic tests, etc. Required to measure adequately non-admitted patient services in psychiatric hospitals and alcohol and drug hospitals. Difficulties were envisaged in using the proposed definitions of an individual or group occasion of service for clients attending psychiatric day care centres. These individuals may receive both types of services during a visit to a centre.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Day program attendances, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.86 KB)

Degree of spread of cancer

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—degree of spread of a cancer, code N
METeOR identifier:	270180
Registration status:	Health, Standard 01/03/2005
Definition:	Degree of spread of cancer is a measure of the progression/extent of cancer at a particular point in time, as represented by a code.
Data Element Concept:	Person with cancer—degree of spread of a cancer

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Localised to the tissue of origin
2	Invasion of adjacent tissue or organs
3	Regional lymph nodes
4	Distant metastases
5	Not Applicable

Supplementary values:

9	Unknown

Collection and usage attributes

Guide for use:

The valid values for the variable are listed below.

CODE 1 Localised to the tissue of origin

Includes a primary cancer where the spread is contained within the organ of origin. Note: this includes in situ breast (D05.0-D05.9) and in situ melanoma (D03.0-D03.9)

Example 1: For colon cancer, the cancer has not progressed into the adventitia (peritoneal layer) surrounding the colon.

Example 2: For breast cancer, the cancer has not progressed into the underlying muscle layer (pectoral) or externally to the skin.

Example 3: For melanoma of the skin, the cancer has not invaded the subcutaneous fat layer (that is, it is contained within the dermis and epidermis).

Example 4: For lung cancer, the cancer has not invaded the pleura.

CODE 2 Invasion of adjacent tissue or organs

A primary cancer has spread to adjacent organs or tissue not forming part of the organ of origin. This category includes sub-cutaneous fat or muscle and organs adjacent to the primary cancer site.

Example 1: For colon cancer, the cancer has progressed into the adventitia (peritoneal layer) surrounding the colon.

Example 2:For breast cancer, the degree of spread has progressed into the underlying muscle layer (pectoral) or externally into the skin.

Example 3: For melanoma of the skin, the cancer has invaded into subcutaneous fat or muscle.

Example 4: For lung cancer, the cancer has invaded the pleura or tissues of the mediastinum.

CODE 3 Regional lymph nodes

The primary cancer has metastasised to the nearby draining lymph nodes. The list below shows the regional lymph nodes by site of primary cancer (International Union Against Cancer's definition).

Head and neck - Cervical nodes

Larynx - Cervical nodes

Thyroid - Cervical and upper mediastinal nodes

Stomach - Perigastric nodes along the lesser and greater curvatures

Colon and Rectum - Pericolic, perirectal, and those located along the ileocolic, right colic, middle colic, left colic, inferior mesenteric and superior rectal

Anal - Perirectal, internal iliac, and inguinal lymph nodes

Liver - Hilar nodes, e.g. the hepatoduodenal ligament

Pancreas - Peripancreatic nodes

Lung - Intrathoracic, scalene and supraclavicular

Breast - Axillary, interpectoral, internal mammary

Cervix - Paracervical, parametrial, hypogastric, common, internal and external iliac, presacral and sacral

Ovary - Hypogastric (obturator), common iliac, external iliac, lateral, sacral, paraortic and inguinal

Prostate and bladder - Pelvic nodes below the bifurcation of the common iliac arteries

Testes - Abdominal, para-aortic and paracaval nodes, the intrapelvic and inguinal nodes

Kidney - Hilar, abdominal, para-aortic or paracaval.

CODE 4 Distant metastases

The primary cancer has spread to sites distant to the primary site, for example liver and lung and bone, or any lymph nodes not stated as regional to the site (see '3 - Regional lymph nodes' above).

CODE 5 Not applicable

This category applies for lymphatic and haematopoietic cancers, e.g. myelomas, leukaemias and lymphomas (C81.0 - C96.9) only.

CODE 9 Unknown

No information is available on the degree of spread at this episode or the available information is insufficient to allow classification into one of the preceding categories.

Data element attributes

Source and reference attributes

Submitting organisation: World Health Organization
New South Wales Health Department

Origin: International Classification of Diseases for Oncology, Second Edition (ICD-O-2) New South Wales Inpatient Statistics Collection Manual-2000/2001

Relational attributes

Related metadata references: Supersedes Degree of spread of cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.6 KB)

Department of Veterans' Affairs file number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—government funding identifier, Department of Veterans' Affairs file number AAXXNNNNA
METeOR identifier:	339127
Registration status:	Health, Standard 29/11/2006 Community services, Standard 31/08/2007
Definition:	A unique personal identifier issued to a veteran by the Department of Veterans' Affairs.
Data Element Concept:	Person—government funding identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	AAXXNNNNA
Maximum character length:	9

Collection and usage attributes

Guide for use:

1st character is the state code (an alphabetic character) - N, V, Q, W, S or T for the appropriate state/territory. Australian Capital Territory is included in New South Wales (N) and Northern Territory with South Australia (S).

Next 7 characters are the file number, made up of:
War code + numeric digits, where:
if War code is 1 alphabetic character, add 6 numeric characters (ANNNNNN)

Where there is no war code as is the case with World War 1 veterans, insert a blank and add 6 numeric characters (NNNNNN)
if War code is 2 alphabetic characters, add 5 numeric characters (AANNNNN)
if War code is 3 alphabetic characters, add 4 numeric characters (AAANNNN)

The 9th character is the segment link. For dependents of veterans, the 9th character is always an alphabetic character. The alphabetic code is generated in the order by which the cards are issued. For example A, B, C, D etc.

CAUTIONARY NOTE: For veterans the 9th character is left blank

Data element attributes

Collection and usage attributes

Collection methods:

The Department of Veterans' Affairs file number should only be collected from persons eligible to receive health services that are to be funded by the DVA. The number may be reported to the appropriate government agency to reconcile payment for

the service provided.

DVA card number:

This number is the digitised version of the file number. If paper claims are optically scanned by the Health Insurance Commission, the digitised version of the file number is picked up by the scanner and converted to the normal file number format. For manual claims, the gold and white cards may be used in conjunction with the data element and an imprinter. This method records the DVA file number and other card details on a manual voucher.

The data should not be used by private sector organisations for any purpose unless specifically authorised by law. For example, private sector organisations should not use the DVA file number for data linking unless specifically authorised by relevant privacy legislation.

This number must be recorded by a service provider each time a service is provided to a person who holds the entitlement for reimbursement purposes.

Comments:

All veterans and veteran community clients are issued with a DVA file number. The veteran community may access many different benefits, ranging from pensions to health services, through their DVA file number.

Note that Veterans may have a Medicare card number and a Department of Veterans Affairs (DVA) number or only a DVA number.

DVA has three (3) types of health cards:

- Gold Card
- White Card
- Repatriation Pharmaceutical Benefits Card.

Each card indicates, to the health provider, the level of health services the holder is eligible for, at the DVA expense.

The Gold card enables the holder to access a comprehensive range of health care and related services, for all conditions, whether they are related to war service or not.

The White card enables the holder to access health care and associated services for war or service-related conditions. Veterans of Australian forces may also be issued this card to receive treatment for malignant cancer, pulmonary tuberculosis and post traumatic stress disorder and, for Vietnam veterans only, anxiety or depression, irrespective of whether these conditions are related to war service or not.

The white card holders are eligible to receive, for specific conditions, treatment from registered medical, hospital, pharmaceutical, dental and allied health care providers with whom DVA has arrangements.

A white card is also issued to eligible ex-service personnel who are from other countries, which enter into arrangements with the Australian government for the treatment of the conditions that these countries accept as war related.

When a gold/white card holder accesses health services at DVA expense, the DVA File Number is critical and should be used. The person's Medicare card number is not required or relevant.

It should be noted that there are a number of gold card holders who do not have a Medicare card.

The Repatriation Pharmaceutical Benefits card is an orange

coloured card issued to eligible veterans and merchant mariners from Britain and the Commonwealth and other allied countries. This card enables the holder to access the range of pharmaceutical items available under the Repatriation Pharmaceutical Benefits Scheme. It does not provide access to other health services.

Source and reference attributes

Origin: Department of Veterans' Affairs

Relational attributes

Related metadata references: Supersedes Person—government funding identifier, Department of Veterans' Affairs file number AAXXNNNN[A] Health, Superseded 29/11/2006

Department of Veterans' Affairs patient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—funding eligibility indicator (Department of Veterans Affairs), code N
METeOR identifier:	270092
Registration status:	Health, Standard 01/03/2005
Definition:	Whether an eligible person's charges for this hospital **admission** are met by the Department of Veterans' Affairs (DVA), as represented by a code.
Context:	Health services
Data Element Concept:	Episode of care—funding eligibility indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:	Refer to the Veterans' Entitlements Act 1986 for details of eligible DVA beneficiaries.
Collection methods:	Whether or not charges for this episode of care are met by the DVA is routinely established as part of hospital admission processes.
Comments:	Eligible veterans and war widow/widowers can receive free treatment at any public hospital, former Repatriation Hospitals (RHs) or a Veteran Partnering (VP) contracted private hospital as a private patient in a shared ward, with the doctor of their choice. Admission to a public hospital does not require prior approval from the DVA. When treatment cannot be provided within a reasonable time in the public health system at a former RH or a private VP hospital, there is a system of contracted non-VP private hospitals which will provide care. Admission to a contracted private hospital requires prior financial authorisation from DVA. Approval may be given to attend a non-contracted private hospital when the service is not available at a public or contracted non-VP private hospital. In an emergency a Repatriation patient can be admitted to the nearest hospital, public or private, without reference to DVA.

If an eligible veteran or war widow/widower chooses to be treated under Veterans' Affairs arrangements, which includes obtaining prior approval for non-VP private hospital care, DVA will meet the full cost of their treatment.

To assist in analyses of utilisation and health care funding.

Relational attributes

Related metadata references:

Supersedes Department of Veterans' Affairs patient, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.86 KB)

Implementation in Data Set Specifications:

Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Dependency in activities of daily living—bathing

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (bathing), code N
METeOR identifier:	270413
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a person's need for assistance with bathing, as represented by a code.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Independent
2	Requires observation or rare physical assistance
3	Cannot perform the activity without some assistance
4	Full assistance required (totally dependent)

Data element attributes

Collection and usage attributes

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

Collection methods:	Commencement of care episode (there may be several visits in which assessment data are gathered).
Comments:	There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use. The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:	Australian Council of Community Nursing Services
Reference documents:	ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:	Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—bed mobility

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (bed mobility), code N
METeOR identifier:	270416
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the level of a person's need for assistance with bed mobility, as represented by a code.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Independent
2	Requires observation or rare physical assistance
3	Cannot perform the activity without some assistance
4	Full assistance required (totally dependent) - a hoist is used
5	2 persons physical assist is required

Data element attributes

Collection and usage attributes

Guide for use: Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification,

	which can be mapped to other classifications and produce equivalent scores. Code 4: A hoist is used. Code 5: 2 persons physical assist is required.
Collection methods:	Commencement of care episode (there may be several visits in which assessment data are gathered).
Comments:	There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use. The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:	Australian Council of Community Nursing Services
Reference documents:	ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:	Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—bladder continence

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (bladder continence), code N
METeOR identifier:	270417
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the level of a person's bladder continence, as represented by a code.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Continent of urine (includes independence in use of device)
2	Incontinent less than daily
3	Incontinent once per 24 hour period
4	Incontinent 2-6 times per 24 hour period
5	Incontinent more than 6 times per 24 hour period
6	Incontinent more than once at night only

Data element attributes

Collection and usage attributes

Guide for use:	Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional

	Independence Measure, Resource Utilisation Groups etc. Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.
Collection methods:	Commencement of care episode (there may be several visits in which assessment data are gathered).
Comments:	There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use. The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:	Australian Council of Community Nursing Services
Reference documents:	ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:	Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—bowel continence

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (bowel continence), code N
METeOR identifier:	270418
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the level of a person's bowel continence, as represented by a code.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Continent of faeces (includes independence in use of device)
2	Incontinent less than daily
3	Incontinent once per 24 hour period
4	Incontinent regularly, more than once per 24 hour period
5	Incontinent more than once at night only

Data element attributes

Collection and usage attributes

Guide for use:	Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

	Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.
Collection methods:	Commencement of care episode (there may be several visits in which assessment data are gathered).
Comments:	There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use. The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:	Australian Council of Community Nursing Services
Reference documents:	ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:	Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—day-time technical nursing care requirement

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—technical nursing care requirement (day-time), total minutes NNN
METeOR identifier:	270420
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a person's need for day-time technical nursing care per week measured in minutes.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—technical nursing care requirement

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	NNN	
Maximum character length:	3	
Supplementary values:	Value	Meaning
	1	No technical care requirements
Unit of measure:	Minute (m)	

Data element attributes

Collection and usage attributes

Guide for use:

Record the minutes of day-time technical care required per week.

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

- medication administration (including injections)

- dressings and other procedures
- venipuncture
- monitoring of dialysis
- implementation of pain management technology.

Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

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

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

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Reference documents: ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references: Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—dressing

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (dressing), code N
METeOR identifier:	270414
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a person's need for assistance with dressing, as represented by a code.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Independent
2	Requires observation or rare physical assistance
3	Cannot perform the activity without some assistance
4	Full assistance required (totally dependent)

Data element attributes

Collection and usage attributes

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

Collection methods:	Commencement of care episode (there may be several visits in which assessment data are gathered).
Comments:	There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use. The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:	Australian Council of Community Nursing Services
Reference documents:	ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:	Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—eating

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (eating), code N
METeOR identifier:	270415
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a person's need for assistance with eating, as represented by a code.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Independent
2	Requires observation or rare physical assistance
3	Cannot perform the activity without some assistance
4	Full assistance required (totally dependent)
5	Tube-fed only

Data element attributes

Collection and usage attributes

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

	equivalent scores.
Collection methods:	Commencement of care episode (there may be several visits in which assessment data are gathered).
Comments:	There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use. The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:	Australian Council of Community Nursing Services
Reference documents:	ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:	Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—evening technical nursing care requirement

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—technical nursing care requirement (evening), total minutes NNN
METeOR identifier:	270421
Registration status:	Health, Standard 01/03/2005
Definition:	A person's need for evening technical nursing care per week measured in minutes.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—technical nursing care requirement

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	NNN	
Maximum character length:	3	
Supplementary values:	Value	Meaning
	1	No technical care requirements
Unit of measure:	Minute (m)	

Data element attributes

Collection and usage attributes

Guide for use:

Record the minutes of evening technical care required per week.

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

- medication administration (including injections)

- dressings and other procedures
- venipuncture
- monitoring of dialysis
- implementation of pain management technology.

Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

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

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

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Reference documents: ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references: Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—extra surveillance

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (extra surveillance), code N
METeOR identifier:	270419
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a person's need for additional individual attention and/or planned intervention in carrying out activities of daily living, as represented by a code.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	No additional attention required
2	Less than 30 minutes individual attention per day
3	More than 30 and more than or equal to 90 minutes individual attention per day
4	Requires at least two hours intervention per week on an episodic basis
5	More than 90 minutes but less than almost constant individual attention
6	Requires almost constant individual attention
7	Cannot be left alone at all

Data element attributes

Collection and usage attributes

Guide for use:

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

- aggressiveness
- wandering
- impaired memory or attention
- disinhibition and other cognitive impairment.

Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

Collection methods:

Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments:

There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Reference documents:

ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:

Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—infrequent technical nursing care requirement

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—technical nursing care requirement (infrequent), total minutes NNN
METeOR identifier:	270423
Registration status:	Health, Standard 01/03/2005
Definition:	A person's need for infrequent technical nursing care per month measured in minutes.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—technical nursing care requirement

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	NNN	
Maximum character length:	3	
Supplementary values:	Value	Meaning
	1	No technical care requirements
Unit of measure:	Minute (m)	

Data element attributes

Collection and usage attributes

Guide for use:

Record the minutes of infrequent technical care required per month.

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

- medication administration (including injections)

- dressings and other procedures
- venipuncture
- monitoring of dialysis
- implementation of pain management technology.

Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

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

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

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Reference documents: ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references: Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—mobility

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (mobility), code N
METeOR identifier:	270410
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a person's need for assistance with mobility, as represented by a code.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Independent
2	Requires observation or rare physical assistance
3	Cannot perform the activity without some assistance
4	Full assistance required (totally dependent)

Data element attributes

Collection and usage attributes

Guide for use:

Applies to walking, walking aid or wheelchair.

Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce

	equivalent scores.
Collection methods:	Commencement of care episode (there may be several visits in which assessment data are gathered).
Comments:	There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use. The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:	Australian Council of Community Nursing Services
Reference documents:	ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCN

Relational attributes

Related metadata references:	Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—night-time technical nursing care requirement

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—technical nursing care requirement (night-time), total minutes NNN
METeOR identifier:	270422
Registration status:	Health, Standard 01/03/2005
Definition:	A person's need for night-time technical nursing care per week measured in minutes.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—technical nursing care requirement

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	NNN	
Maximum character length:	3	
Supplementary values:	Value	Meaning
	1	No technical care requirements
Unit of measure:	Minute (m)	

Data element attributes

Collection and usage attributes

Guide for use:

Record the minutes of night-time technical care required per week.

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

- medication administration (including injections)

- dressings and other procedures
- venipuncture
- monitoring of dialysis
- implementation of pain management technology.

Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

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

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

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Reference documents: ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references: Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—toileting

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (toileting), code N
METeOR identifier:	270411
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a person's need for assistance with toileting, as represented by a code.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Independent
2	Requires observation or rare physical assistance
3	Cannot perform the activity without some assistance
4	Full assistance required (totally dependent)

Data element attributes

Collection and usage attributes

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

Collection methods: Commencement of care episode (there may be several visits in which assessment data is gathered).

Comments: There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in the Guide for Use.

The Person - Dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Reference documents: ACCNS 1997. Community nursing minimum data set Australian version 2.0: data dictionary and guidelines. Melbourne:ACCNS.

Relational attributes

Related metadata references: Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Dependency in activities of daily living—transferring

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dependency in activities of daily living (transferring), code N
METeOR identifier:	270412
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of a person's need for assistance with transferring, as represented by a code.
Context:	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person—dependency in activities of daily living

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Independent
2	Requires observation or rare physical assistance
3	Cannot perform the activity without some assistance
4	Full assistance required (totally dependent)
5	Person is bedfast

Data element attributes

Collection and usage attributes

Guide for use: Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce

	equivalent scores. Code 5: Person is bedfast.
Collection methods:	Commencement of care episode (there may be several visits in which assessment data are gathered).
Comments:	There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use. The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:	Australian Council of Community Nursing Services
Reference documents:	ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:	Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)

Depreciation expenses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Organisation—depreciation expenses, total Australian currency NNNNN.N
METeOR identifier:	359967
Registration status:	Health, Standard 05/12/2007
Definition:	Expenses of an organisation consisting of consumption of fixed capital (depreciation), in Australian currency.
Data Element Concept:	Organisation—depreciation expenses

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	NNNNN.N
Maximum character length:	6
Unit of measure:	Australian currency (AU$)

Source and reference attributes

Submitting organisation:	Health Expenditure Advisory Committee

Data element attributes

Collection and usage attributes

Guide for use:	Data are collected and nationally collated for the reporting period - the financial year ending 30th June each year. Depreciation expenses are to be reported in millions to the nearest 100,000 e.g. $4,064,000 should be reported as $4.1 million. When revenue from transactions are offset against expenses from transactions, the result equates to the net operating balance in accordance with Australian Accounting Standards Board 1049 (September 2006). Depreciation represents the expensing of a long-term asset over its useful life and is related to the basic accounting principle of matching revenue and expenses for the financial period. Depreciation charges for the current financial year only should be shown as expenditure. Where intangible assets are amortised (such as with some private hospitals) this should also be included in recurrent expenditure.
Collection methods:	Depreciation expenses are to be reported for the *Health industry relevant organisation type* and *Typeof health and health related functions* data elements. *Health industry relevant organisation type* State and territory health authorities are **NOT** to report the following codes: Codes 106–109; 111; 115–119; 123; 201 and 203

Type of health and health related functions

State and territory health authorities are **NOT** to report the following codes:

Codes 199; 299; 303–305; 307; 499; 503–504; 599; 601–603; 688; 699

Comments: In accounting terms, expenses are consumptions or losses of future economic benefits in the form of reductions in assets or increases in liabilities of the entity (other than those relating to distributions to owners) that result in a decrease in equity or net worth during the reporting period.

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Origin: Australian Bureau of Statistics: Government Finance Statistics 1998, Cat. No. 5514.0.

Australian Bureau of Statistics 2006. Australian System of Government Finance Statistics: Concepts, sources and methods, 2005. Cat. no. 5514.0.55.001 Canberra: ABS.

Australian Accounting Standards Board 1049, September 2006, <www.asb.com.au>

Relational attributes

Related metadata references: Is used in the formation of Organisation—expenses, total Australian currency NNNNN.N Health, Standard 05/12/2007

Implementation in Data Set Specifications: Government health expenditure organisation expenditure data cluster Health, Standard 05/11/2007

Diabetes status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—diabetes mellitus status, code NN
METeOR identifier:	270194
Registration status:	Health, Standard 01/03/2005
Definition:	Whether a person has or is at risk of diabetes, as represented by a code.
Data Element Concept:	Person—diabetes mellitus status

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
01	Type 1 diabetes
02	Type 2 diabetes
03	Gestational diabetes mellitus (GDM)
04	Other (secondary diabetes)
05	Previous gestational diabetes mellitus (GDM)
06	Impaired fasting glucose (IFG)
07	Impaired glucose tolerance (IGT)
08	Not diagnosed with diabetes
09	Not assessed

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Note that where there is a Gestational diabetes mellitus (GDM) or Previous GDM (i.e. permissible values 3 & 5) and a current history of Type 2 diabetes then record 'Code 2' Type 2 diabetes.

This same principle applies where a history of either Impaired fasting glycaemia (IFG) or Impaired glucose tolerance (IGT) and a current history and Type 2 diabetes, then record 'Code 2' Type 2 diabetes.

CODE 01 Type 1 diabetes

Beta-cell destruction, usually leading to absolute insulin deficiency. Includes those cases attributed to an autoimmune process, as well as those with beta-cell destruction and who are prone to ketoacidosis for which neither an aetiology nor pathogenesis is known (idiopathic). It does not include those forms of beta-cell destruction or failure to which specific causes can be assigned (e.g. cystic fibrosis, mitochondrial defects). Some subjects with Type 1 diabetes can be identified at earlier clinical stages than 'diabetes mellitus'.

CODE 02 Type 2 diabetes

Type 2 includes the common major form of diabetes, which results from defect(s) in insulin secretion, almost always with a major contribution from insulin resistance.

CODE 03 Gestational diabetes mellitus (GDM)

GDM is a carbohydrate intolerance resulting in hyperglycaemia of variable severity with onset or first recognition during pregnancy. The definition applies irrespective of whether or not insulin is used for treatment or the condition persists after pregnancy. Diagnosis is to be based on the Australian Diabetes in Pregnancy Society (ADIPS) Guidelines.

CODE 04 Other (secondary diabetes)

This categorisation include less common causes of diabetes mellitus, but are those in which the underlying defect or disease process can be identified in a relatively specific manner. They include, for example, genetic defects of beta-cell function, genetic defects in insulin action, diseases of the exocrine pancreas, endocrinopathies, drug or chemical-induced, infections, uncommon forms of immune-mediated diabetes, other genetic syndromes sometimes associated with diabetes.

CODE 05 Previous GDM

Where the person has a history of GDM.

CODE 06 Impaired fasting glycaemia (IFG)

IFG or 'non-diabetic fasting hyperglycaemia' refers to fasting glucose concentrations, which are lower than those required to diagnose diabetes mellitus but higher than the normal reference range. An individual is considered to have IFG if they have a fasting plasma glucose of 6.1 or greater and less than 7.0 mmol/L if challenged with an oral glucose load, they have a fasting plasma glucose concentration of 6.1 mmol/L or greater, but less than 7.0 mmol/L, AND the 2 hour value in the Oral Glucose Tolerance Test (OGTT) is less than 7.8 mmol/L.

CODE 07 Impaired glucose tolerance (IGT)

IGT is categorised as a stage in the natural history of disordered carbohydrate metabolism; subjects with IGT have an increased risk of progressing to diabetes. IGT refers to a metabolic state intermediate between normal glucose homeostasis and diabetes. Those individuals with IGT manifest glucose intolerance only when challenged with an oral glucose load. IGT is diagnosed if the 2 hour value in the OGTT is greater than 7.8 mmol/L. and less than 11.1 mmol/L AND the fasting plasma glucose concentration is less than 7.0 mmol/L.

CODE 08 Not diagnosed with diabetes

The subject has no known diagnosis of Type 1, Type 2, GDM, Previous GDM, IFG, IGT or Other (secondary diabetes).

CODE 09 Not assessed

The subject has not had their diabetes status assessed.

CODE 99 Not stated/inadequately described

This code is for unknown or information unavailable.

Collection methods: The diagnosis is derived from and must be substantiated by clinical documentation.

Source and reference attributes

Origin: Developed based on Definition, Diagnosis and Classification of Diabetes Mellitus and its Complications Part 1: Diagnosis and

Classifications of Diabetes Mellitus Provisional Report of a World Health Organization Consultation (Alberti & Zimmet 1998).

Data element attributes

Collection and usage attributes

Collection methods:

Diabetes (clinical):

A type of diabetes should be recorded and coded for each episode of patient care.

Source and reference attributes

Submitting organisation:

Cardiovascular Data Working Group

National Diabetes Data Working Group

Relational attributes

Related metadata references:

Supersedes Diabetes status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (27.25 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

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

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

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

Information specific to this data set:

People with diabetes have two to five times increased risk of developing heart, stroke and vascular disease (Zimmet & Alberti 1997). Cardiovascular disease is the most common cause of death in people with diabetes.

Diabetes is also an important cause of stroke, and people with diabetes may have a worse prognosis after stroke.

Heart, stroke and vascular disease and diabetes share common risk factors, but also diabetes is an independent risk factor for heart, stroke and vascular disease.

During the 1995 National Health Survey, about 15 per cent of those with diabetes reported having heart disease, at almost six times the rate noted among people without diabetes. In 1996-97, almost one in six hospital separations, with coronary heart disease as any listed diagnosis, also had diabetes recorded as an associated diagnosis. Heart disease appears earlier in life and is more often fatal among those with diabetes.

Diabetes may accentuate the role of elevated blood pressure in stroke. The incidence and prevalence of peripheral vascular disease in those with diabetes increase with the duration of the peripheral vascular disease.

Mortality is increased among patients with peripheral vascular disease and diabetes, in particular if foot ulcerations, infection or gangrene occur. There is limited information on whether the presence of heart, stroke and

vascular disease promotes diabetes in some way.

High blood pressure, high cholesterol and obesity are often present along with diabetes. As well as all being independent cardiovascular risk factors, when they are in combination with glucose intolerance (a feature of diabetes) and other risk factors such as physical inactivity and smoking, these factors present a greater risk for heart, stroke and vascular disease.

Evidence is accumulating that high cholesterol and glucose intolerance, which often occur together, may have a common aetiological factor. Despite these similarities, trends in cardiovascular mortality and diabetes incidence and mortality are moving in opposite directions.

While the ageing of the population following reductions in cardiovascular mortality may have contributed to these contrasting trends, the role of other factors also needs to be clearly understood if common risk factor prevention strategies are to be considered. (From Commonwealth Department of Health & Aged Care and Australian Institute of Health and Welfare (1999) National Health Priority Areas Report: Cardiovascular Health).

In settings such as general practice where the monitoring of a person's health is ongoing and where diabetes status can change over time, the service contact date should be recorded.

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

Uncontrolled diabetes leads to a variety of complications, often resulting in limitation of activity, disability, illness and premature mortality. Therefore ongoing assessment is required to identify people at risk of developing complications so that early preventive strategies can be applied. Although there is no cure for diabetes, with modern treatment most people can lead a full and active life and avoid long-term complications.

Aetiological classifications contained in the scientific paper 'Definition, Diagnosis and Classification of Diabetes Mellitus and its Complications Part 1: Diagnosis and Classifications of Diabetes Mellitus Provisional Report of a WHO Consultation (Alberti & Zimmet 1998)'.

Diabetes therapy type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—diabetes therapy type, code NN
METeOR identifier:	270236
Registration status:	Health, Standard 01/03/2005
Definition:	The type of diabetes therapy the person is currently receiving, as represented by a code.
Data Element Concept:	Person—diabetes therapy type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
01	Diet and exercise only
02	Oral hypoglycaemic - sulphonylurea only
03	Oral hypoglycaemic - biguanide (eg metformin) only
04	Oral hypoglycaemic - alpha-glucosidase inhibitor only
05	Oral hypoglycaemic - thiazolidinedione only
06	Oral hypoglycaemic - meglitinide only
07	Oral hypoglycaemic - combination (eg biguanide & sulphonylurea)
08	Oral hypoglycaemic - other
09	Insulin only
10	Insulin plus oral hypoglycaemic
98	Nil - not currently receiving diabetes treatment

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 01 Diet & exercise only

This code includes the options of generalised prescribed diet; avoid added sugar/simple carbohydrates (CHOs); low joule diet; portion exchange diet and uses glycaemic index and a recommendation for increased exercise.

CODE 98 Nil - not currently receiving diabetes treatment

This code is used when there is no current diet, tablets or insulin therapy(ies).

CODE 99 Not stated/inadequately described

Use this code when missing information.

Data element attributes

Collection and usage attributes

Collection methods:

To be collected at the commencement of treatment and at each review.

Comments:

In settings where the monitoring of a person's health is ongoing and where management can change over time (such as general practice), the Service contact—service contact date, DDMMYYYY should be recorded.

The main use of this data element is to enable categorisation of management regimes against best practice for diabetes.

Source and reference attributes

Submitting organisation:

National Diabetes Data Working Group

Cardiovascular Data Working Group

Reference documents:

Berkow R, editor. The Merck Manual. 16th ed. Rahway (New Jersey, USA): Merck Research Laboratories; 1992.

Relational attributes

Related metadata references:

Supersedes Diabetes therapy type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.14 KB)

Implementation in Data Set Specifications:

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

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

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

Diabetes (clinical) DSS Health, Superseded 21/09/2005

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

The objectives and priorities of treatment must be tailored to the individual considering age, sex, weight and individual health status.

An individual management plan for each patient should include the following:

- establishment of targets of treatment
- healthy eating plan
- education in self-monitoring,
- adjustment of treatment and in approaches to coping with emergencies
- exercise program
- risk factor reduction, e.g. smoking cessation
- use of oral hypoglycaemic agents, if required
- use of insulin, if required
- screening for and treatment of complications of diabetes.

In addition to glycaemic control, management of diabetes of either type requires close attention to other risk factors for the development of complications, and the impact of lifestyle changes on blood glucose levels should be monitored. In patients with Type 2 diabetes, an increase in

physical activity is essential in management of lipids and glucose level. Increased physical activity has been recognised as perhaps the most feasible way of modifying glucose intolerance, a risk factor for developing diabetes and macrovascular disease (Guest & O'Dea 1992).

Diagnosis related group

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA
METeOR identifier:	270195
Registration status:	Health, Standard 01/03/2005
Definition:	A patient classification scheme which provides a means of relating the number and types of patients treated in a hospital to the resources required by the hospital, as represented by a code.
Data Element Concept:	Episode of admitted patient care—diagnosis related group

Value domain attributes

Representational attributes

Classification scheme:	Australian Refined Diagnosis Related Groups version 5.1
Representation class:	Code
Data type:	String
Format:	ANNA
Maximum character length:	4

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Origin:	National Centre for Classification in Health National Health Data Committee

Relational attributes

Related metadata references:	See also Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN Health, Standard 01/03/2005 Is formed using Episode of care—mental health legal status, code N Health, Standard 01/03/2005 Is formed using Episode of admitted patient care—number of leave days, total N[NN] Health, Standard 01/03/2005 Is formed using Person—weight (measured), total grams NNNN Health, Standard 01/03/2005 Is formed using Person—date of birth, DDMMYYYY Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 20/06/2005 Is formed using Episode of care—additional diagnosis, code (ICD-

10-AM 3rd edn) ANN{.N[N]} Health, Superseded 28/06/2004

Is formed using Episode of admitted patient care—admission date, DDMMYYYY Health, Standard 01/03/2005

Is formed using Episode of care—principal diagnosis, code (ICD-10-AM 3rd edn) ANN{.N[N]} Health, Superseded 28/06/2004

Is formed using Episode of admitted patient care—intended length of hospital stay, code N Health, Standard 01/03/2005

Is formed using Episode of admitted patient care—separation mode, code N Health, Standard 01/03/2005

Is formed using Episode of admitted patient care—procedure, code (ICD-10-AM 3rd edn) NNNNN-NN Health, Superseded 28/06/2004

Is formed using Episode of admitted patient care—separation date, DDMMYYYY Health, Standard 01/03/2005

Is formed using Person—sex, code N Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 10/02/2006

Supersedes Diagnosis related group, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.02 KB)

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Difficulty with activities

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—level of difficulty with activities in life areas, code (ICF 2001) N
METeOR identifier:	320120
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The level of difficulty a person has in performing the tasks and actions involved in specified life areas, as represented by a code.
Context:	Human functioning and disability
Data Element Concept:	Person—level of difficulty with activities in a life area

Value domain attributes

Representational attributes

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

Permissible values: / *Supplementary values:*

Value	Meaning
0	No difficulty
1	Mild difficulty
2	Moderate difficulty
3	Severe difficulty
4	Complete difficulty
8	Not specified
9	Not applicable

Collection and usage attributes

Guide for use:

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

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

Difficulties with activities can arise when there is a qualitative or quantitative alteration in the way in which these activities are carried out. Difficulty includes matters such as 'with pain', 'time taken', 'number of errors', clumsiness', 'modification of manner in which an activity is performed' e.g. sitting to get dressed instead of standing. 'Difficulty' is a combination of the frequency with which the problem exists, the duration of the problem and the intensity of the problem. Activity limitations are assessed against a generally accepted population standard,

relative to cultural and social expectations.

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

The user will select the code that most closely summarises, in terms of duration, frequency, manner or outcome, the level of difficulty of the person for whom the data is recorded.

CODE 0 No difficulty in this life area

Is used when there is no difficulty in performing this activity. This scale has a margin of error of 5%. [0-4%]

CODE 1 Mild difficulty

Is recorded for example, when the level of difficulty is below the threshold for medical intervention, the difficulty is experienced less than 25% of the time, and/or with a low alteration in functioning which may happen occasionally over the last 30 days. [5-24%]

CODE 2 Moderate difficulty

Is used for example when the level of difficulty is experienced less than 50% of the time and/or with a significant, but moderate effect on functioning (Up to half the scale of total performance) which may happen regularly over the last 30 days. [25-49%]

CODE 3 Severe difficulty

Is used for example when performance in this life area can be achieved, but with only extreme difficulty, and/or with an extreme effect on functioning which may happen often over the last 30 days. [50-95%]

CODE 4 Complete difficulty

Is used when the person can not perform in this life area due of the difficulty in doing so. This scale has a margin of error of 5%. [96-100%]

CODE 8 Not specified

Is used where a person has difficulty with activities in a life area but there is insufficient information to use codes 0-4.

CODE 9 Not applicable

Is used where a life area is not applicable to this person, e.g. domestic life for a child under 5.

Source and reference attributes

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

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

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

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

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

Data element attributes

Collection and usage attributes

Guide for use: This data element, in conjunction with Person—activities and participation life area, code (ICF 2001) AN[NNN], indicates the presence and extent of activity limitation in a given domain of activity.

Source and reference attributes

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

Relational attributes

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

Division of General Practice number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Division of general practice—organisation identifier, NNN
METeOR identifier:	270014
Registration status:	Health, Standard 01/03/2005
Definition:	The unique identifier for the Division of general practice number as designated by the Commonwealth Government of Australia. Each separately administered Division of general practice has a unique identifying number.
Data Element Concept:	Division of general practice—organisation identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	Number
Format:	NNN
Maximum character length:	3

Data element attributes

Source and reference attributes

Submitting organisation:	Cardiovascular Data Working Group
Origin:	The actual Division of General Practice numbers can be obtained by selecting the individual State or Territory from the *Divisions Directory* found within the Australian Division of General Practice website

Relational attributes

Related metadata references:	Supersedes Division of general practice number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.19 KB)
Implementation in Data Set Specifications:	Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006 Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007 Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Dyslipidaemia treatment indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—dyslipidaemia treatment with anti-lipid medication indicator (current), code N
METeOR identifier:	302440
Registration status:	Health, Standard 21/09/2005
Definition:	Whether a person is being currently treated for dyslipidaemia using anti-lipid medication, as represented by a code.
Data Element Concept:	Person—dyslipidaemia treatment with anti-lipid medication indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes: Record if a person is being treated for dyslipidaemia using anti-lipid medication. CODE 2 No: Record if a person is not being treated for dyslipidaemia using anti-lipid medication.
Collection methods:	Ask the individual if he/she is currently treated with anti-lipid medication. Alternatively obtain the relevant information from appropriate documentation.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:	Supersedes Person—dyslipidaemia treatment status (anti-lipid medication), code N Health, Superseded 21/09/2005

Implementation in Data Set Specifications:

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

Dyslipidaemia is associated with many health problems including diabetes and hypertension. It is often related to overweight and obesity. Usually caused by inappropriate diet and sedentary lifestyle, dyslipidaemia has been reaching epidemic proportions. Active lifestyle and low calorie diets are the best way of prevention, however sometimes for the treatment of dyslipidaemia the use of pharmacotherapy is required. Abnormal levels of blood lipids are associated with increased risk of developing CHD especially in diabetic patients.

The risk of coronary and other macrovascular disorders is 2-5 times higher in people with diabetes than in non-diabetic subjects and increases in parallel with the degree of dyslipidaemia. Diabetes mellitus greatly modifies the significance of lipoprotein levels, particularly when associated with smoking, hypertension and family history of CVD. Poor metabolic control of diabetes seems to have impact on abnormal lipoprotein level. Primary dyslipidaemia, due to genetic and environmental (especially dietary) factors, is diagnosed if secondary causes have been excluded (hypothyroidism, nephrotic syndrome, cholestasis, anorexia nervosa, diabetes mellitus Type 2, renal impairment).

Electrocardiogram change location

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—electrocardiogram change location, code N
METeOR identifier:	285071
Registration status:	Health, Standard 04/06/2004
Definition:	The area in which the change is located on the 12-lead electrocardiogram (ECG) of the person, as represented by a code.
Data Element Concept:	Person—electrocardiogram change location

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Inferior leads: II, III, aVF
	2	Anterior leads: V1 to V4
	3	Lateral leads: I, aVL, V5 to V6
	4	True posterior: V1 V2
	8	None
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 4 True posterior: V1 V2 True posterior is relevant only for tall R waves.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Collection methods:	More than one code may be recorded. Report in order of significance. Record all codes that apply (codes 8 and 9 are excluded from multiple coding).

Source and reference attributes

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

Relational attributes

Related metadata references:	See also Person—electrocardiogram change type, code N Health, Standard 04/06/2004 Supersedes Electrocardiogram (ECG) change - location, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.19 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Electrocardiogram change type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—electrocardiogram change type, code N
METeOR identifier:	285307
Registration status:	Health, Standard 04/06/2004
Definition:	The type of change to the heart rhythm seen on the person's electrocardiogram (ECG), as represented by a code.
Data Element Concept:	Person—electrocardiogram change type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	ST-segment elevation >= 1 mm (0.1 mV) in >= 2 contiguous limb leads
2	ST-segment elevation >= 2 mm (0.2 mV) in >= 2 contiguous chest leads
3	ST-segment depression >= 0.5 mm (0.05 mV) in >= 2 contiguous leads (includes reciprocal changes)
4	T-wave inversion >= 1 mm (0.1 mV)
5	Significant Q waves
6	Bundle branch block (BBB)
7	Non-specific
8	No changes

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 ST-segment elevation >= 1 mm (0.1 mV) in >= 2 contiguous limb leads

ST-segment elevation indicates greater than or equal to 1 mm (0.1 mV) elevation in 2 or more contiguous limb leads.

CODE 2 ST-segment elevation >= 2 mm (0.2 mV) in >= 2 contiguous chest leads

ST-segment elevation indicates greater than or equal to 2 mm (0.2 mV) elevation in 2 or more contiguous chest leads.

CODE 3 ST-segment depression >= 0.5 mm (0.05 mV) in >= 2 contiguous leads (includes reciprocal changes)

ST-segment depression of at least 0.5 mm (0.05 mV) in 2 or more contiguous leads (includes reciprocal changes).

CODE 4 T-wave inversion >= 1 mm (0.1 mV)

T-wave inversion of at least 1 mm (0.1 mV) including inverted T

waves that are not indicative of acute MI.

CODE 5 Significant Q waves

Q waves refer to the presence of Q waves that are greater than or equal to 0.03 seconds in width and greater than or equal to 1 mm (0.1 mV) in depth in at least 2 contiguous leads.

CODE 6 Bundle branch block (BBB)

Bundle branch block pattern

CODE 7 Non-specific

Changes not meeting the above criteria.

CODE 8 No changes

No ECG changes.

CODE 9 Not stated/inadequately described

Includes unknown.

Data element attributes

Collection and usage attributes

Guide for use:

More than one code may be recorded.

Record all that apply (codes 7, 8 and 9 are excluded from multiple coding).

Source and reference attributes

Submitting organisation:

Acute coronary syndrome data working group

Steward:

The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:

See also Person—electrocardiogram change location, code N Health, Standard 04/06/2004

Supersedes Electrocardiogram (ECG) change - type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.29 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

For Acute coronary syndrome (ACS) reporting, used to determine diagnostic strata.

Electronic communication address (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—electronic communication address, text [X(250)]
METeOR identifier:	287469
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	A unique combination of characters used as input to electronic communication equipment for the purpose of contacting a person, as represented by text.
Data Element Concept:	Person (address)—electronic communication address

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(250)]
Maximum character length:	250

Data element attributes

Collection and usage attributes

Guide for use:

Multiple electronic communication addresses (for example, multiple phone numbers, fax numbers and e-mail) may be recorded as required. Each instance should have an appropriate Electronic communication medium and usage code assigned.

Universal Resource Locator (URL)

One form of electronic address used as a locator for an internet-based web site.

Example: http://www.aihw.gov.au This is the full address, however, it is not essential to record 'http://www' as the commonly used internet browsers assume these characters are included. Therefore, the URL address could be recorded as 'aihw.gov.au'.

Email addresses

Email addresses are a combination of a username and an internet domain name (URL) joined by an @ symbol. The use of the full URL is not valid in an email address.

Example: myuserid@bigpond.net.au

Telephone numbers

- Record the prefix plus telephone number. For example, 08 8226 6000 or 0417 123456.
- Do not record punctuation in telephone numbers. For example, (08) 8226 6000 or 08-8226 6000 would not be correct.

Unknown contact details

Leave the field blank.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS 4846 Health Care Provider Identification, 2004, Sydney: Standards Australia
Reference documents:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia In AS5017 this data element is represented by 'Telephone number (client)'. In AS4846 this data element is represented by 'Provider electronic communication details'. Refer to the current standard for more details.

Relational attributes

Implementation in Data Set Specifications:	Health care client identification DSS Health, Standard 04/05/2005 Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Electronic communication address (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—electronic communication address, text [X(250)]
METeOR identifier:	287480
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	A unique combination of characters used as input to electronic communication equipment for the purpose of contacting an organisation, as represented by text.
Data Element Concept:	Service provider organisation (address)—electronic communication address

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(250)]
Maximum character length:	250

Data element attributes

Collection and usage attributes

Guide for use:

Multiple electronic communication addresses (for example, multiple phone numbers, fax numbers and e-mail) may be recorded as required. Each instance should have an appropriate Electronic communication medium and usage code assigned.

Universal Resource Locator (URL)

One form of electronic address used as a locator for an internet-based web site.

Example: http://www.aihw.gov.au This is the full address, however, it is not essential to record 'http://www' as the commonly used internet browsers assume these characters are included. Therefore, the URL address could be recorded as 'aihw.gov.au'.

Email addresses

Email addresses are a combination of a username and an internet domain name (URL) joined by an @ symbol. The use of the full URL is not valid in an email address.

Example: myuserid@bigpond.net.au

Telephone numbers

Record the prefix plus telephone number. For example, 08 8226 6000 or 0417 123456.
Do not record punctuation in telephone numbers. For example, (08) 8226 6000 or 08-8226 6000 would not be correct.
Unknown contact details

Leave the field blank.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS 4846 Health Care Provider Identification, 2004, Sydney: Standards Australia
Reference documents:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia In AS5017 this data element is represented by 'Telephone number (client)'. In AS4846 this data element is represented by 'Provider electronic communication details'. Refer to the current standard for more details.

Relational attributes

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

Electronic communication medium (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—electronic communication medium, code N
METeOR identifier:	287519
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	A type of communication mechanism used by a person, as represented by a code.
Data Element Concept:	Person (address)—electronic communication medium

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Telephone (excluding mobile telephone)
2	Mobile (cellular) telephone
3	Facsimile machine
4	Pager
5	e-mail
6	URL
8	Other

Data element attributes

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS 4846 Health Care Provider Identification, 2004, Sydney: Standards Australia
Reference documents:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia In AS4846 alternative alphabetic codes are presented. Refer to the current standard for more details.

Relational attributes

Implementation in Data Set Specifications: Health care client identification DSS Health, Standard 04/05/2005

Information specific to this data set:
Multiple electronic communication addresses (for example, multiple phone numbers, fax numbers and e−mail) may be recorded as required. Each instance should have an appropriate Electronic communication medium and Electronic communication usage code

assigned.

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

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

Information specific to this data set:
Multiple electronic communication addresses (for example, multiple phone numbers, fax numbers and e-mail) may be recorded as required. Each instance should have an appropriate Electronic communication medium and Electronic communication usage code assigned.

Electronic communication medium (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—electronic communication medium, code N
METeOR identifier:	287521
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	A type of communication mechanism used by an organisation, as represented by a code.
Data Element Concept:	Service provider organisation (address)—electronic communication medium

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Telephone (excluding mobile telephone)
2	Mobile (cellular) telephone
3	Facsimile machine
4	Pager
5	e-mail
6	URL
8	Other

Data element attributes

Collection and usage attributes

Guide for use:	Multiple electronic communication addresses (for example, multiple phone numbers, fax numbers and e-mail) may be recorded as required. Each instance should have an appropriate Electronic communication medium and Electronic communication usage code assigned.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS 4846 Health Care Provider Identification, 2004, Sydney: Standards Australia
Reference documents:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia In AS4846 alternative alphabetic codes are presented. Refer to

the current standard for more details.

Relational attributes

Implementation in Data Set Specifications:

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

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

Information specific to this data set:
Multiple electronic communication addresses (for example, multiple phone numbers, fax numbers and e-mail) may be recorded as required. Each instance should have an appropriate Electronic communication medium and Electronic communication usage code assigned.

Electronic communication usage code (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—electronic communication usage, code N
METeOR identifier:	287579
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The manner of use that a person applies to an electronic communication address, as represented by a code.
Data Element Concept:	Person (address)—electronic communication usage code

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Business use only
2	Personal use only
3	Both business and personal use

Data element attributes

Collection and usage attributes

Guide for use:	Only applicable to individuals, and not organisations.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	AS 4846 Health Care Provider Identification, 2004, Sydney: Standards Australia
Reference documents:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia In AS5017 an alternative data element is presented as 'Telephone number type (client)'. In AS4846 this data element is called 'Provider electronic communication type'. In both instances alternative alphabetic codes are presented. Refer to the current standard for more details.

Relational attributes

Implementation in Data Set Specifications:	Health care client identification DSS Health, Standard 04/05/2005 Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard

04/07/2007

Information specific to this data set:
Multiple electronic communication addresses (for example, multiple phone numbers, fax numbers and e-mail) may be recorded as required. Each instance should have an appropriate Electronic communication medium and Electronic communication usage code assigned.

Emergency department arrival mode - transport

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—transport mode (arrival), code N
METeOR identifier:	270000
Registration status:	Health, Standard 01/03/2005
Definition:	The mode of transport by which the person arrives at the emergency department, as represented by a code.
Data Element Concept:	Non-admitted patient emergency department service episode—transport mode

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Ambulance, air ambulance or helicopter rescue service
2	Police/correctional services vehicle
8	Other

Supplementary values:

9	Not stated/unknown

Collection and usage attributes

Guide for use: CODE 8 Other

Includes walking, private transport, public transport, community transport, and taxi.

Data element attributes

Source and reference attributes

Submitting organisation: National reference group for non-admitted patient data development, 2001-02

Relational attributes

Related metadata references: Supersedes Emergency department arrival mode - transport, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.8 KB)

Implementation in Data Set Specifications: Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Emergency department date of commencement of service event

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—service commencement date, DDMMYYYY
METeOR identifier:	313801
Registration status:	Health, Standard 07/12/2005
Definition:	The date on which a non-admitted patient emergency department service event commences.
Context:	Emergency Department care
Data Element Concept:	Non-admitted patient emergency department service episode—service commencement date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	In an Emergency Department the service event commences when the medical officer (or, if no medical officer is on duty in the Emergency Department, a treating nurse) provides treatment or diagnostic service. The date of triage is recorded separately. The commencement of a service event does not include contact associated with triage.
Collection methods:	Collected in conjunction with non-admitted patient emergency department service commencement time.

Source and reference attributes

Submitting organisation:	Australian Government Department of Health and Ageing

Relational attributes

Related metadata references:	Supersedes Health service event—service commencement date, DDMMYYYY Health, Superseded 07/12/2005
Implementation in Data Set Specifications:	Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Emergency department departure date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Emergency department stay—physical departure date, DDMMYYYY
METeOR identifier:	322597
Registration status:	Health, Standard 24/03/2006
Definition:	The date on which a patient departs an emergency department after a stay.
Context:	Emergency department care.
Data Element Concept:	Emergency department stay—physical departure date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use: Each emergency department stay should include a non-admitted patient emergency department service episode component. The value of the episode end status code should guide the selection of the value to be recorded in this field:

- If the patient is subsequently admitted then record the date the patient leaves the Emergency Department to go to the admitted patient facility. Physically moving the patient to a bed in an emergency department specialist care unit (including EMU, short stay ward, emergency care unit or observation unit) is defined as representing departure from the emergency department.
- If the service episode is completed without the patient being admitted, including referral to another hospital, record the date the patient leaves the Emergency Department.
- If the patient did not wait record the date the patient leaves the Emergency Department or was first noticed as having left.
- If the patient left at their own risk record the date the patient leaves the Emergency Department.
- If the patient died in the Emergency Department record the date of death.
- If the patient was dead on arrival then record the date of presentation at the Emergency Department.

Collection methods: Collected in conjunction with emergency department stay

physical departure time.

Comments: This data element has been developed for the purpose of State and Territory compliance with the Australian Health Care Agreement and the agreed national access performance indicator.

Source and reference attributes

Submitting organisation: Australian Government Department of Health and Ageing

Relational attributes

Implementation in Data Set Specifications:

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Emergency department departure time

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Emergency department stay—physical departure time, hhmm
METeOR identifier:	322610
Registration status:	Health, Standard 24/03/2006
Definition:	The time at which a patient departs an emergency department after a stay.
Context:	Emergency department care.
Data Element Concept:	Emergency department stay—physical departure time

Value domain attributes

Representational attributes

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

Source and reference attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

Each emergency department stay should include a non-admitted patient emergency department service episode component. The value of the episode end status code should guide the selection of the value to be recorded in this field:

- If the patient is subsequently admitted then record the time the patient leaves the Emergency Department to go to the admitted patient facility. Physically moving the patient to a bed in an emergency department specialist care unit (including EMU, short stay ward, emergency care unit or observation unit) is defined as representing departure from the emergency department.
- If the service episode is completed without the patient being admitted, including referral to another hospital, record the time the patient leaves the Emergency Department.
- If the patient did not wait record the time the patient leaves the Emergency Department or was first noticed as having left.
- If the patient left at their own risk record the time the patient leaves the Emergency Department.
- If the patient died in the Emergency Department record the time of death.
- If the patient was dead on arrival then record the time of

presentation at the Emergency Department.

Collection methods: Collected in conjunction with emergency department stay physical departure date.

Comments: This data element has been developed for the purpose of State and Territory compliance with the Australian Health Care Agreement and the agreed national access performance indicator.

Source and reference attributes

Submitting organisation: Australian Government Department of Health and Ageing

Relational attributes

Implementation in Data Set Specifications: Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Emergency department episode end date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—episode end date, DDMMYYYY
METeOR identifier:	322616
Registration status:	Health, Standard 24/03/2006
Definition:	The date on which the non-admitted patient emergency department service episode ends.
Data Element Concept:	Non-admitted patient emergency department service episode—episode end date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

A non-admitted patient emergency department service episode ends when either the patient is admitted or, if the patient is not to be admitted, when the patient is recorded as ready to leave the emergency department or when they are recorded as having left at their own risk.

For patients who subsequently undergo a formal admission an admitted patient episode of care should be recorded. The end of the non-admitted patient emergency department service episode should indicate the commencement of the admitted episode of care.

Source and reference attributes

Submitting organisation: Australian Government Department of Health and Ageing

Relational attributes

Implementation in Data Set Specifications:

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008 *Implementation start date:* 01/07/2008

Emergency department episode end time

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—episode end time, hhmm
METeOR identifier:	322621
Registration status:	Health, Standard 24/03/2006
Definition:	The time at which the non-admitted patient emergency department service episode ends.
Data Element Concept:	Non-admitted patient emergency department service episode—episode end time

Value domain attributes

Representational attributes

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

Source and reference attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	A non-admitted patient emergency department service episode ends when either the patient is admitted or, if the patient is not to be admitted, when the patient is recorded as ready to leave the emergency department or when they are recorded as having left at their own risk. For patients who subsequently undergo a formal admission an admitted patient episode of care should be recorded. The end of the non-admitted patient emergency department service episode should indicate the commencement of the admitted episode of care.

Source and reference attributes

Submitting organisation:	Australian Government Department of Health and Ageing

Relational attributes

Implementation in Data Set Specifications:	Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Emergency department service episode end status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—episode end status, code N
METeOR identifier:	322641
Registration status:	Health, Standard 24/03/2006
Definition:	The status of the patient at the end of the non-admitted patient emergency department service episode, as represented by a code.
Data Element Concept:	Non-admitted patient emergency department service episode—episode end status

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Admitted to this hospital (including to units or beds within the emergency department)
2	Non-admitted patient emergency department service episode completed - departed without being admitted or referred to another hospital
3	Non-admitted patient emergency department service episode completed - referred to another hospital for admission
4	Did not wait to be attended by a health care professional
5	Left at own risk after being attended by a health care professional but before the non-admitted patient emergency department service episode was completed
6	Died in emergency department as a non-admitted patient
7	Dead on arrival, not treated in emergency department

Collection and usage attributes

Guide for use:

CODE 2 Non-admitted patient emergency department service episode completed - departed without being admitted or referred to another hospital

This code includes patients who departed under their own care, under police custody, under the care of a residential aged care facility or other carer. Code 2 excludes those who died in the emergency department, which should be coded to Code 6.

Source and reference attributes

Submitting organisation: Australian Government Department of Health and Ageing

Data element attributes

Collection and usage attributes

Guide for use: A non-admitted patient emergency department service episode ends when either the patient is admitted or, if the patient is not to be admitted, when the patient is recorded as ready to leave the emergency department or when they are recorded as having left at their own risk.

Collection methods: Some data systems may refer to this data element as 'Departure status'.

Source and reference attributes

Submitting organisation: Australian Government Department of Health and Ageing

Relational attributes

Related metadata references: Supersedes Non-admitted patient emergency department service episode—patient departure status, code N Health, Superseded 24/03/2006

Implementation in Data Set Specifications: Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Emergency department time of commencement of service event

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—service commencement time, hhmm
METeOR identifier:	313806
Registration status:	Health, Standard 07/12/2005
Definition:	The time at which a non-admitted patient emergency department service event commences.
Context:	Emergency Department care
Data Element Concept:	Non-admitted patient emergency department service episode—service commencement time

Value domain attributes

Representational attributes

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

Source and reference attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	In an Emergency Department the service event commences when the medical officer (or, if no medical officer is on duty in the Emergency Department, a treating nurse) provides treatment or diagnostic service. The time of triage is recorded separately. The commencement of a service event does not include contact associated with triage.
Collection methods:	Collected in conjunction with non-admitted patient emergency department service episode service commencement date.

Source and reference attributes

Submitting organisation:	Australian Government Department of Health and Ageing

Relational attributes

Related metadata references:	Supersedes Health service event—service commencement time, hhmm Health, Superseded 07/12/2005
Implementation in Data Set Specifications:	Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006 *Implementation start date:* 01/07/2005

Implementation end date: 30/06/2006

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Emergency department waiting time to admission

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—waiting time (to hospital admission), total hours and minutes NNNN
METeOR identifier:	270004
Registration status:	Health, Standard 01/03/2005
Definition:	The time elapsed for each patient from presentation to the emergency department to **admission** to hospital.
Data Element Concept:	Non-admitted patient emergency department service episode—waiting time (to hospital admission)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NNNN
Maximum character length:	4
Unit of measure:	Hour and minute

Collection and usage attributes

Guide for use:	HHMM

Data element attributes

Collection and usage attributes

Guide for use:	Calculated from admission date and time minus date and time patient presents for those emergency department patients who are admitted.
Collection methods:	To be collected on patients presenting to emergency department for unplanned care in public hospitals with emergency department and private hospitals providing contracted services for the public sector.
Comments:	This is a critical waiting times metadata item. It is used to examine the length of waiting time, for performance indicators and benchmarking. Information based on this metadata item will have many uses including to assist in the planning and management of hospitals and in health care research.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Is formed using Episode of admitted patient care—admission date, DDMMYYYY Health, Standard 01/03/2005 Is formed using Health service event—presentation time,

hhmm Health, Standard 01/03/2005

Is formed using Non-admitted patient emergency department service episode—patient departure status, code N Health, Superseded 24/03/2006

Is formed using Episode of admitted patient care—admission time, hhmm Health, Standard 01/03/2005

Is formed using Health service event—presentation date, DDMMYYYY Health, Standard 01/03/2005

Supersedes Emergency department waiting time to admission, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.55 KB)

Emergency department waiting time to service delivery

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—waiting time (to service delivery), total minutes NNNNN
METeOR identifier:	270007
Registration status:	Health, Standard 01/03/2005
Definition:	The time elapsed in minutes for each patient from presentation in the emergency department to a service occurrence of a specific event related to service delivery.
Data Element Concept:	Non-admitted patient emergency department service episode—waiting time

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NNNNN
Maximum character length:	5
Unit of measure:	Minute (m)

Data element attributes

Collection and usage attributes

Guide for use:	Calculated 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.
Comments:	It is recognised that at times of extreme urgency or multiple synchronous presentations, or if no medical officer is on duty in the emergency department, this service may be provided by a nurse.

Source and reference attributes

Submitting organisation:	National reference group for non-admitted patient data development, 2001-02

Relational attributes

Related metadata references:	Is formed using Health service event—service commencement time, hhmm Health, Superseded 07/12/2005 Is formed using Health service event—service commencement date, DDMMYYYY Health, Superseded 07/12/2005 Supersedes Emergency department waiting time to service delivery, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.69 KB) Is formed using Health service event—presentation time, hhmm Health, Standard 01/03/2005 Is formed using Health service event—presentation date,

	DDMMYYYY Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005

Employee expenses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Organisation—employee related expenses, total Australian currency NNNNN.N
METeOR identifier:	359947
Registration status:	Health, Standard 05/12/2007
Definition:	Expenses of an organisation consisting mainly of wages, salaries and supplements, superannuation employer contributions, and workers compensation premiums and payouts, in Australian currency.
Data Element Concept:	Organisation—employee related expenses

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	NNNNN.N
Maximum character length:	6
Unit of measure:	Australian currency (AU$)

Source and reference attributes

Submitting organisation:	Health Expenditure Advisory Committee

Data element attributes

Collection and usage attributes

Guide for use:

Data are collected and nationally collated for the reporting period - the financial year ending 30th June each year.

Employee related expenses are to be reported in millions to the nearest 100,000 e.g. $4,064,000 should be reported as $4.1 million.

When revenue from transactions are offset against expenses from transactions, the result equates to the net operating balance in accordance with Australian Accounting Standards Board 1049 (September 2006).

Includes:

- Salaries, wages and supplements for all employees of the organisation (including contract staff employed by an agency, provided staffing data is also available). This is to include all paid leave (recreation, sick and long-service) and salary and wage payments relating to workers compensation leave.
- Superannuation employer contributions paid or, for an emerging cost scheme, that should be paid (as determined by an actuary) on behalf of establishment employees either by the establishment or a central administration such as a state health authority, to a superannuation fund providing

retirement and related benefits to establishment employees, for a financial year.

- Workers compensation premiums and payments

Collection methods:

Employee related expenses are to be reported for the *Health industry relevant organisation type* and *Typeof health and health related functions* data elements.

Health industry relevant organisation type

State and territory health authorities are **NOT** to report the following codes:

Codes 106–109; 111; 115–119; 123; 201 and 203

Type of health and health related functions

State and territory health authorities are **NOT** to report the following codes:

Codes 199; 299; 303–305; 307; 499; 503–504; 599; 601–603; 688; 699

Comments:

In accounting terms, expenses are consumptions or losses of future economic benefits in the form of reductions in assets or increases in liabilities of the entity (other than those relating to distributions to owners) that result in a decrease in equity or net worth during the reporting period.

Source and reference attributes

Submitting organisation:

Health Expenditure Advisory Committee

Origin:

Australian Bureau of Statistics: Government Finance Statistics 1998, Cat. No. 5514.0.

Australian Bureau of Statistics 2006. Australian System of Government Finance Statistics: Concepts, sources and methods, 2005. Cat. no. 5514.0.55.001 Canberra: ABS.

Australian Accounting Standards Board 1049, September 2006, <www.asb.com.au>

Relational attributes

Related metadata references:

Is used in the formation of Organisation—expenses, total Australian currency NNNNN.N Health, Standard 05/12/2007

Implementation in Data Set Specifications:

Government health expenditure organisation expenditure data cluster Health, Standard 05/11/2007

Employment status (admitted patient)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—labour force status, acute hospital and private psychiatric hospital admission code N
METeOR identifier:	269948
Registration status:	Health, Standard 01/03/2005
Definition:	Self-reported employment status of a person, immediately prior to **admission** to an acute or private psychiatric hospital, as represented by a code.
Context:	The Australian Health Ministers' Advisory Council Health Targets and Implementation Committee (1988) identified socioeconomic status as the most important factor explaining health differentials in the Australian population. The committee recommended that national health statistics routinely identify the various groups of concern. This requires routine recording in all collections of indicators of socioeconomic status. In order of priority, these would be: employment status, income, occupation and education.
Data Element Concept:	Person—labour force status

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Unemployed / pensioner
2	Other

Data element attributes

Collection and usage attributes

Collection methods:

In practice, this metadata item and current or last occupation could probably be collected with a single question, as is done in Western Australia:
Occupation?
For example:

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

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

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Employment status - acute hospital and private psychiatric hospital admissions, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Employment status—public psychiatric hospital admissions

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—labour force status, public psychiatric hospital admission code N
METeOR identifier:	269955
Registration status:	Health, Standard 01/03/2005
Definition:	Self-reported employment status of a person, immediately prior to **admission** to a public psychiatric hospital, as represented by a code.
Context:	The Australian Health Ministers' Advisory Council Health Targets and Implementation Committee (1988) identified socioeconomic status as the most important factor explaining health differentials in the Australian population. The committee recommended that national health statistics routinely identify the various groups of concern. This requires routine recording in all collections of indicators of socioeconomic status. In order of priority, these would be: employment status, income, occupation and education.
Data Element Concept:	Person—labour force status

Value domain attributes

Representational attributes

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

Permissible values:

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

Data element attributes

Collection and usage attributes

Collection methods:

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

Occupation?

For example:

- housewife or home duties
- pensioner miner

- tree feller
- retired electrician
- unemployed trades assistant
- child
- student
- accountant

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

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Employment status - public psychiatric hospital admissions, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.63 KB)

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Environmental factor

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—environmental factor, code (ICF 2001) AN[NNN]
METeOR identifier:	320207
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The physical, social and attitudinal environment in which people live and conduct their lives, as represented by a code.
Context:	The environment in which a person functions or experiences disability.
Data Element Concept:	Person—environmental factor

Value domain attributes

Representational attributes

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

Collection and usage attributes

Guide for use:

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

Environmental factors represent the circumstances in which the individual lives. These factors are conceived as immediate (e.g. physical features of the environment, social environment) and societal (formal and informal social structures, services and systems). Different environments may have a very different impact on the same individual with a given health condition.

Facilitators are features of the environment that have a positive effect on **disability**. Barriers are features of the environment that have a negative effect on disability.

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

The value domain below refers to the highest hierarchical level (ICF chapter level). Data collected at this level, in association with *Extent of environmental factor influence code [X]N* will use the codes as indicated. The full range of the permissible values together with definitions can be found in the *Environmental Factors* component of the ICF.

Code e1 Products and technology

Code e2 Natural environment and human-made changes to environment
Code e3 Support and relationships
Code e4 Attitudes
Code e5 Services, systems and policies

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

An example of a value domain at the 3 digit level from the Environmental factors component may include:

CODE e225 Climate
CODE e240 Light
CODE e250 Sound
CODE e255 Vibration
CODE e260 Air quality

An example of a value domain at the 4 digit level from the the environmental factors component may include:

CODE e1151 Assistive products and technology for personal use in daily life
CODE e1201 Assistive products and technology for personal indoor and outdoor mobility and transportation
CODE e2151 Assistive products and technology for communication
CODE e1301 Assistive products and technology for education
CODE e1351 Assistive products and technology for employment
CODE e1401 Assistive products and technology for culture, recreation and sport
CODE e1451 Assistive products and technology for the practice of religion and spirituality

The prefix ***e*** denotes the domains within the component of *Environmental Factors*.

Source and reference attributes

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

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

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

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

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

Data element attributes

Collection and usage attributes

Guide for use: This data element is a neutral list of environmental factors. It may be used, in conjunction with Person—extent of environmental factor influence, code (ICF 2001) [X]N, in health,

community services and other disability-related data collections to record the environmental factors that facilitate or inhibit optimum functioning at the body, person or societal level. Identification of environmental factors may assist in determining appropriate interventions to support the person to achieve optimum functioning.

Source and reference attributes

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

Relational attributes

Implementation in Data Set Specifications: Environmental factors cluster Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Episode of residential care end date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of residential care—episode end date, DDMMYYYY
METeOR identifier:	270062
Registration status:	Health, Standard 01/03/2005
Definition:	Date on which a **resident** formally or statistically **ends an episode of residential care**.
Data Element Concept:	Episode of residential care—episode end date

Value domain attributes

Representational attributes

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

Data element attributes

Relational attributes

Related metadata references:

Supersedes Episode of residential care end date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.57 KB)

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Data in this field must:

- be ≤ last day of reference period
- be ≥ first day of reference period
- be ≥ Episode of residential care start date

Episode of residential care end mode

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of residential care—episode end mode, code N
METeOR identifier:	270063
Registration status:	Health, Standard 01/03/2005
Definition:	The reason for **ending an episode of residential care**, as represented by a code.
Data Element Concept:	Episode of residential care—episode end mode

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Died
2	Left against clinical advice / at own risk
3	Commenced leave where there is no intention that the resident returns to overnight residential care within seven days
4	Other end of residential care at this establishment
5	End of reference period

Supplementary values:

Value	Meaning
9	Unknown/not stated/inadequately described

Collection and usage attributes

Guide for use:

CODES 1 - 4 These codes refer to the formal episode of residential care end.

CODE 1 Died

CODE 2 Left against clinical advice / at own risk

CODE 3 Commenced leave where there is no intention that the resident returns to overnight residential care within seven days

CODE 5 End of reference period

This code refers to the statistical episode of residential care end.

CODE 9 Unknown/not stated/inadequately described

This code refers to other.

Data element attributes

Relational attributes

Related metadata references:	Supersedes Episode of residential care end mode, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.35 KB)
Implementation in Data Set	Residential mental health care NMDS 2005-2006 Health,

Specifications:

Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Episode of residential care start date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of residential care—episode start date, DDMMYYYY
METeOR identifier:	270064
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which the **resident** formally or statistically **starts an episode of residential care**.
Data Element Concept:	Episode of residential care—episode start date

Value domain attributes

Representational attributes

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

Data element attributes

Relational attributes

Related metadata references:

Supersedes Episode of residential care start date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.09 KB)

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Right justified and zero filled.

episode of residential care start date ≤ episode of residential care end date.

episode of residential care start date ≥ date of birth.

Episode of residential care start mode

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of residential care—episode start mode, code N
METeOR identifier:	270075
Registration status:	Health, Standard 01/03/2005
Definition:	The reason for starting an **episode of residential care**, as represented by a code.
Data Element Concept:	Episode of residential care—episode start mode

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Unplanned return from leave where there had been no intention that the resident would return to overnight residential care at the establishment within seven days
2	Other (i.e. start of a new residential stay)
3	Start of a new reference period

Supplementary values:

9	Unknown/not stated/inadequately described

Collection and usage attributes

Guide for use:

CODES 1-2 These codes refer to the formal episode of residential care start.

CODE 1 Unplanned return from leave where there had been no intention that the resident would return to overnight residential care at the establishment within seven days

CODE 2 Other (i.e. start of a new residential stay)

CODE 3 Start of a new reference period

This code refers to the statistical episode of residential care start.

CODE 9 Unknown/not stated/inadequately described

This code refers to other.

Data element attributes

Relational attributes

Related metadata references:	Supersedes Episode of residential care start mode, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.86 KB)
Implementation in Data Set Specifications:	Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005
	Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Erectile dysfunction

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (male)—erectile dysfunction, code N
METeOR identifier:	270132
Registration status:	Health, Standard 01/03/2005
Definition:	Whether a male individual has a history of erection failure or has received treatment to achieve erection sufficient for penetration in the last 12 months and prior, as represented by a code.
Data Element Concept:	Person (male)—erectile dysfunction

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Erectile dysfunction- developed in the last 12 months
2	Erectile dysfunction- developed prior to the last 12 months
3	No erectile dysfunction

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	Determine whether this developed within or prior to the last 12 months.
Collection methods:	Ask the individual if he has a history of treatment or failure to achieve or maintain erection sufficient for penetration.

Data element attributes

Collection and usage attributes

Guide for use:	Record for male patients only.

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Erectile dysfunction, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.14 KB)
Implementation in Data Set	Diabetes (clinical) DSS Health, Superseded 21/09/2005

Specifications: Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

Erectile problems occur in up to 50% of men with diabetes who are over 40 years old.

Erectile dysfunction may be due to psychological causes, macrovascular disease or pelvic autonomic neuropathy. An organic cause is more likely in the presence of other macro or micro vascular complications.

Establishment identifier

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—organisation identifier (Australian), NNX[X]NNNNN
METeOR identifier:	269973
Registration status:	Health, Standard 01/03/2005
Definition:	The identifier for the establishment in which episode or event occurred. Each separately administered health care establishment to have a unique identifier at the national level.
Data Element Concept:	Establishment—organisation identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	NNX[X]NNNNN
Maximum character length:	9

Data element attributes

Collection and usage attributes

Guide for use:	Concatenation of: Australian state/territory identifier (character position 1); Sector (character position 2); Region identifier (character positions 3-4); and Organisation identifier (state/territory), (character positions 5-9).
Comments:	Establishment identifier should be able to distinguish between all health care establishments nationally.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Establishment identifier, version 4, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.97 KB) Is formed using Establishment—Australian state/territory identifier, code N Health, Standard 01/03/2005 Is formed using Establishment—organisation identifier (state/territory), NNNNN Health, Standard 01/03/2005 Is formed using Establishment—sector, code N Health, Standard 01/03/2005 Is formed using Establishment—region identifier, X[X] Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient palliative care NMDS 2008-09 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Community mental health care 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Community mental health establishments NMDS 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

Elective surgery waiting times (census data) NMDS Health, Standard 07/12/2005

Implementation start date: 30/09/2006

Elective surgery waiting times (census data) NMDS Health, Superseded 07/12/2005

Implementation start date: 30/09/2002

Implementation end date: 30/06/2006

Elective surgery waiting times (removals data) NMDS Health, Standard 07/12/2005

Implementation start date: 01/07/2006

Elective surgery waiting times (removals data) NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2002

Implementation end date: 30/06/2006

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

Health care client identification DSS Health, Standard 04/05/2005

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Outpatient care NMDS Health, Superseded 04/07/2007

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Outpatient care NMDS Health, Standard 04/07/2007

Implementation start date: 01/07/2007

Perinatal NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Perinatal NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health,

Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Establishment number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—organisation identifier (state/territory), NNNNN
METeOR identifier:	269975
Registration status:	Health, Standard 01/03/2005
Definition:	An identifier for an establishment, unique within the state or territory.
Data Element Concept:	Establishment—organisation identifier (state/territory)

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	Number
Format:	NNNNN
Maximum character length:	5

Data element attributes

Collection and usage attributes

Comments:	Identifier should be a unique code for the health care establishment used in that state/territory.

Relational attributes

Related metadata references:

Supersedes Establishment number, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (14.61 KB)

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

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

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

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

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

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

Health care client identification DSS Health, Standard 04/05/2005

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Establishment sector

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—sector, code N
METeOR identifier:	269977
Registration status:	Health, Standard 01/03/2005
Definition:	A section of the health care industry with which a health care establishment can identify, as represented by a code.
Data Element Concept:	Establishment—sector

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Public
2	Private

Data element attributes

Collection and usage attributes

Guide for use:

Alcohol and other drug treatment services NMDS:

This data element is used to differentiate between establishments run by the government sector (code 1) and establishments that receive some government funding but are run by the non-government sector (code 2).

CODE 1 is to be used when the establishment:

- operates from the public accounts of a Commonwealth, state or territory government or is part of the executive, judicial or legislative arms of government,
- is part of the general government sector or is controlled by some part of the general government sector,
- provides government services free of charge or at nominal prices, and
- is financed mainly from taxation.

CODE 2 is to be used only when the establishment:

- is not controlled by government,
- is directed by a group of officers, an executive committee or a similar body
- elected by a majority of members, and
- may be an income tax exempt charity.

Relational attributes

Related metadata references: Supersedes Establishment sector, version 4, DE, NHDD,

NHIMG, Superseded 01/03/2005.pdf (15.79 KB)

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

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Community mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

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

Health care client identification DSS Health, Standard 04/05/2005

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

CODE 2 is to be used for private hospitals and residential mental health care services operated by non-government organisations. Code 2 will mean 'private' for specialised mental health services with a service setting of 'admitted' and 'non-government organisation' for specialised mental health services with a service setting of 'residential'.

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Residential mental health care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

CODE 1 is to be used for government-operated residential mental health care services.

CODE 2 to be used for residential mental health care services operated by non-government organisations.

Establishment type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—establishment type, sector and services provided code AN.N{.N}
METeOR identifier:	269971
Registration status:	Health, Standard 01/03/2005
Definition:	Type of establishment (defined in terms of legislative approval, service provided and patients treated) for each separately administered establishment, as represented by a code.
Data Element Concept:	Establishment—establishment type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	AN.N{.N}
Maximum character length:	6

Permissible values:

Value	Meaning
R1.1	Public acute care hospital
R1.2	Private acute care hospital
R1.3.1	Veterans Affairs hospital
R1.3.2	Defence force hospital
R1.3.3	Other Commonwealth hospital
R2.1	Public psychiatric hospital
R2.2	Private psychiatric hospital
R3.1	Private charitable nursing home for the aged
R3.2	Private profit nursing home for the aged
R3.3	Government nursing home for the aged
R3.4	Private charitable nursing home for young disabled
R3.5	Private profit nursing home for young disabled
R3.6	Government nursing home for young disabled
R5.2	State government hostel for the aged
R4.1	Public alcohol and drug treatment centre
R4.2	Private alcohol and drug treatment centre
R5.1	Charitable hostels for the aged
R5.3	Local government hostel for the aged
R5.4	Other charitable hostel
R5.5	Other State government hostel
R5.6	Other Local government hostel
R6.1	Public hospice
R6.2	Private hospice

N7.1	Public day centre/hospital
N7.2	Public freestanding day surgery centre
N7.3	Private day centre/hospital
N7.4	Private freestanding day surgery centre
N8.1.1	Public community health centre
N8.1.2	Private (non-profit) community health centre
N8.2.1	Public domiciliary nursing service
N8.2.2	Private (non-profit) domiciliary nursing service
N8.2.3	Private (profit) domiciliary nursing service

Collection and usage attributes

Guide for use:

Establishments are classified into 10 major types subdivided into major groups:

- residential establishments (R)
- non-residential establishments (N)

CODE R1 Acute care hospitals

Establishments which provide at least minimal medical, surgical or obstetric services for inpatient treatment and/or care, and which provide round-the-clock comprehensive qualified nursing service as well as other necessary professional services. They must be licensed by the state health department, or controlled by government departments. Most of the patients have acute conditions or temporary ailments and the average stay per admission is relatively short.

Hospitals specialising in dental, ophthalmic aids and other specialised medical or surgical care are included in this category. Hospices (establishments providing palliative care to terminally ill patients) that are freestanding and do not provide any other form of acute care are classified to R6.

CODE R2 Psychiatric hospitals

Establishments devoted primarily to the treatment and care of inpatients with psychiatric, mental, or behavioural disorders. Private hospitals formerly approved by the Commonwealth Department of Health under the Health Insurance Act 1973 (Cwlth) (now licensed/approved by each state health authority), catering primarily for patients with psychiatric or behavioural disorders are included in this category.

Centres for the non-acute treatment of drug dependence, developmental and intellectual disability are not included here (see below). This code also excludes institutions mainly providing living quarters or day care.

CODE R3 Nursing homes

Establishments which provide long-term care involving regular basic nursing care to chronically ill, frail, disabled or convalescent persons or senile inpatients. They must be approved by the Commonwealth Department of Health and Family Services and/or licensed by the State, or controlled by Government departments.

Private profit nursing homes are operated by private profit-making individuals or bodies.

Private charitable nursing homes are participating nursing homes operated by religious and charitable organisations.

Government nursing homes are nursing homes either operated

by or on behalf of a state or territory Government.

CODE R4 Alcohol and drug treatment centres

Freestanding centres for the treatment of drug dependence on an inpatient basis.

CODE R5 Hostels and residential services

Establishments run by public authorities or registered non-profit organisation to provide board, lodging or accommodation for the aged, distressed or disabled who cannot live independently but do not need nursing care in a hospital or nursing home. Only hostels subsidised by the Commonwealth are included. Separate dwellings are not included, even if subject to an individual rental rebate arrangement. Residents are generally responsible for their own provisions, but may be provided in some establishments with domestic assistance (meals, laundry, personal care). Night shelters providing only casual accommodation are excluded.

CODE R6 Hospices

Establishments providing palliative care to terminally ill patients. Only freestanding hospices which do not provide any other form of acute care are included in this category.

CODE N7 Same-day establishments

This code includes both the traditional day centre/hospital and also freestanding day surgery centres.

Day centres/hospitals are establishments providing a course of acute treatment on a full-day or part-day non-residential attendance basis at specified intervals over a period of time. Sheltered workshops providing occupational or industrial training are excluded.

Freestanding day surgery centres are hospital facilities providing investigation and treatment for acute conditions on a day-only basis and are approved by the Commonwealth for the purposes of basic table health insurance benefits.

CODE N8 Non-residential health services

Services administered by public authorities or registered non-profit organisations which employ full-time equivalent medical or paramedical staff (nurses, nursing aides, physiotherapists, occupational therapists and psychologists, but not trade instructors or teachers). This definition distinguishes health services from welfare services (not within the scope of the National Minimum Data Project) and thereby excludes such services as sheltered workshops, special schools for the intellectually disabled, meals on wheels and baby clinics offering advisory services but no actual treatment. Non-residential health services should be enumerated in terms of services or organisations rather than in terms of the number of sites at which care is delivered.

Non-residential health services provided by a residential establishment (for example, domiciliary nursing service which is part of a public hospital) should not be separately enumerated.

CODE N8.1 Community health centres

Public or registered non-profit establishments in which a range of non-residential health services is provided in an integrated and coordinated manner, or which provides for the coordination of health services elsewhere in the community.

CODE N8.2 Domiciliary nursing service

Public or registered non-profit or profit-making establishments providing nursing or other professional paramedical care or treatment to patients in their own homes or in (non-health) residential institutions. Establishments providing domestic or housekeeping assistance are excluded by the general definition above.

Comments: Note that national minimum data sets currently include only community health centres and domiciliary nursing services.

Data element attributes

Collection and usage attributes

Comments: In the current data element, the term establishment is used in a very broad sense to mean bases, whether institutions, organisations or the community from which health services are provided. Thus, the term covers conventional health establishments and also organisations which may provide services in the community.

This metadata item is currently under review by the Establishments Framework Working Group of the Health Data Standards Committee. Recommendations will provide a comprehensive coverage of the health service delivery sector.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Establishment type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (31.17 KB)

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

Implementation in Data Set Specifications: Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Extended wait patient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—extended wait patient indicator, code N
METeOR identifier:	269964
Registration status:	Health, Standard 01/03/2005
Definition:	Whether a patient is an extended wait patient, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode—extended wait patient indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Extended wait patient
2	Other patient

Data element attributes

Collection and usage attributes

Guide for use:	A patient is classified as an extended wait patient if the patient is in clinical urgency category 3 at the time of admission or at a census time and has been waiting for the elective surgery for more than one year.
Comments:	This metadata item is used to identify clinical urgency category 3 patients who had waited longer than one year at admission or have waited longer than one year at the time of a census. An extended wait patient is not an overdue patient as there is no maximum desirable waiting time specified for patients in clinical urgency category 3 as they have been assessed as not having a clinically urgent need for the awaited procedure.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Extended wait patient, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.78 KB) Is formed using Elective surgery waiting list episode—waiting time (at a census date), total days N[NNN] Health, Standard 01/03/2005 Is formed using Elective surgery waiting list episode—waiting

time (at removal), total days N[NNN] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Elective surgery waiting times (census data) NMDS Health, Standard 07/12/2005

Implementation start date: 30/09/2006

Elective surgery waiting times (census data) NMDS Health, Superseded 07/12/2005

Implementation start date: 30/09/2002

Implementation end date: 30/06/2006

Elective surgery waiting times (removals data) NMDS Health, Standard 07/12/2005

Implementation start date: 01/07/2006

Elective surgery waiting times (removals data) NMDS Health, Superseded 07/12/2005

Implementation start date: 01/07/2002

Implementation end date: 30/06/2006

Extent of participation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—extent of participation in a life area, code (ICF 2001) N
METeOR identifier:	320219
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The degree of participation by an individual in a specified life area, as represented by a code.
Context:	Human functioning and disability
Data Element Concept:	Person—extent of participation in a life area

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
0	Full participation
1	Mild participation restriction
2	Moderate participation restriction
3	Severe participation restriction
4	Complete participation restriction

Supplementary values:

8	Not specified
9	Not applicable

Collection and usage attributes

Guide for use:

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

In the context of health, participation is involvement in a life situation. Participation restrictions are problems an individual may experience in involvement of life situations.

This metadata item may be used to describe the extent of **participation** in life situations for an individual with a health condition. The standard or norm to which an individual's participation is compared is that of an individual without a similar health condition in that particular society. The participation restriction records the discordance between the experienced participation and the expected participation of an individual without a health condition. The definition of 'particular society' is not specified and will inevitably give rise to different interpretations. If limiting the interpretation, it will be necessary to state the factors which are taken into account,

for example, age, gender, ethnicity, religion, education, locality (town, state, rural, remote, urban).

The user will select the code that most closely summarises, in terms of duration, frequency, manner or outcome, the level of participation of the person for whom the data is recorded.

CODE 0 Full participation

Used when the person participates in this life area in the same way in terms of duration, frequency, manner or outcome as other individuals without a similar health condition in that particular society

CODE 1 Mild participation restriction

Used for example, when the person is restricted in their participation less than 25% of the time, and/or with a low alteration in functioning which may happen occasionally over the last 30 days

CODE 2 Moderate participation restriction

Used for example, when the person is restricted in their participation between 26% and 50% of the time with a significant, and/or with a moderate effect on functioning (Up to half the total scale of performance) which may happen regularly over the last 30 days

CODE 3 Severe participation restriction

Used for example, when participation in this life area can be achieved, but only rarely and/or with an extreme effect on functioning which may happen often over the last 30 days

CODE 4 Complete participation restriction

Used when the person can not participate in this life area. This scale has a margin of error of 5%

CODE 8 Not specified

Used when a person's participation in a life area is restricted but there is insufficient information to use codes 0-4

CODE 9 Not applicable

Used when participation in a life area is not relevant, such as employment for an infant.

Source and reference attributes

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

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

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

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

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

Data element attributes

Collection and usage attributes

Guide for use:

Extent of participation is always associated with a health condition. For example, a restriction in participation in 'community, social and civic life' may be recorded when the person has had a stroke, but not when the restriction is associated only with personal preferences, without a related health condition. A value is attached to restriction of participation (i.e. a participation restriction is a disadvantage). The value is dependent on cultural norms, so that an individual may be disadvantaged in one group or location and not in another place.

This data element is used in conjunction with a specified Activities and participation life area (ICF 2001) AN[NNN]. For example, a 'mild restriction in participation in exchange of information'.

Source and reference attributes

Submitting organisation:

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

Relational attributes

Implementation in Data Set Specifications:

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

External cause (admitted patient)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—external cause, code (ICD-10-AM 6th edn) ANN{.N[N]}
METeOR identifier:	361926
Registration status:	Health, Standard 05/02/2008
Definition:	The environmental event, circumstance or condition as the cause of injury, poisoning and other adverse effect, as represented by a code.
Data Element Concept:	Injury event—external cause

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	This code must be used in conjunction with an injury or poisoning code and can be used with other disease codes. 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. External cause codes V01 to Y34 must be accompanied by an activity code.
Comments:	Enables categorisation of injury and poisoning according to factors important for injury control. This information is necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research. It is also used as a quality of care indicator of adverse patient outcomes. An extended activity code is being developed in consultation with the National Injury Surveillance Unit, Flinders University, Adelaide.

Source and reference attributes

Origin:

National Centre for Classification in Health

National Data Standards for Injury Surveillance Advisory Group

National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Injury event—external cause, code (ICD-10-AM 5th edn) ANN{.N[N]} Health, Superseded 05/02/2008

Implementation in Data Set Specifications:

Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:
As a minimum requirement, the external cause codes must be listed in the ICD-10-AM classification.

Injury surveillance DSS Health, Standard 05/02/2008

Information specific to this data set:
As a minimum requirement, the external cause codes must be listed in the ICD-10-AM (3rd edition) classification.

External cause (non-admitted patient)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—external cause, non-admitted patient code NN
METeOR identifier:	269988
Registration status:	Health, Standard 01/03/2005
Definition:	Environmental event, circumstance or condition as the cause of injury, poisoning or other adverse effect to a non-admitted patient.
Context:	Injury surveillance: Enables categorisation of injury and poisoning according to factors important for injury control. This information is necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research.
Data Element Concept:	Injury event—external cause

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
01	Motor vehicle - driver
02	Motor vehicle - passenger or unspecified occupant
03	Motorcycle - driver
04	Motorcycle - passenger or unspecified
05	Pedal cyclist or pedal cycle passenger
06	Pedestrian
07	Other or unspecified transport-related circumstance
08	Horse-related (includes fall from, struck or bitten by)
09	Fall - low (on same level or
10	Fall - high (drop of 1 metre or more)
11	Drowning, submersion - swimming pool
12	Drowning, submersion - other than swimming pool (excludes drowning associated with water craft)
13	Other threat to breathing (including strangling and asphyxiation)
14	Fire, flames, smoke
15	Hot drink, food, water, other fluid, steam, gas or vapour

16	Hot object or substance, not otherwise specified
17	Poisoning - drugs or medicinal substance
18	Poisoning - other substance
19	Firearm
20	Cutting, piercing object
21	Dog-related
22	Animal-related (excluding Horse and Dog)
23	(deleted)
24	Machinery in operation
25	Electricity
26	Hot conditions (natural origin) sunlight
27	Cold conditions (natural origins)
28	Other specified external cause
29	Unspecified external cause
30	Struck by or collision with person
31	Struck by or collision with object

Collection and usage attributes

Comments: This code list has been derived from the ICD-10-AM external cause classification.

Source and reference attributes

Reference documents: International Classification of Diseases - Tenth Revision - Australian Modification (3rd edition 2002)

Data element attributes

Collection and usage attributes

Guide for use: This metadata item is for use in injury surveillance purposes only, when it is not possible to use a complete ICD-10-AM code (e.g. Non-admitted patients in emergency departments). Select the item which best characterises the circumstances of the injury, on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate select the one that comes first in the code list. The external cause - non-admitted patient group must always be accompanied by an external cause - human intent code (see metadata item Injury event—external cause, non-admitted patient human intent code NN).

Comments: This metadata item has been developed to cater for the information requirements of the wide range of settings where injury surveillance is undertaken and do not have the capability of recording the complete ICD-10-AM external cause codes. Further information on the national injury surveillance program can be obtained from the National Injury Surveillance Unit, Flinders University, Adelaide.

Source and reference attributes

Origin: National Centre for Classification in Health
National Data Standards for Injury Surveillance Advisory

	Group National Health Data Committee
Reference documents:	International Classification of Diseases - Tenth Revision - Australian Modification (3rd Edition 2002) National Centre for Classification in Health, Sydney

Relational attributes

Related metadata references:	Supersedes External cause - non-admitted patient, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (20.95 KB)

External cause—human intent

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—human intent of injury, code NN
METeOR identifier:	268944
Registration status:	Health, Standard 01/03/2005
Definition:	The clinician's assessment identifying the most likely role of human intent in the occurrence of the injury or poisoning, as represented by a code.
Data Element Concept:	Injury event—human intent of injury

Value domain attributes

Representational attributes

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

Permissible values:

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

Collection and usage attributes

Guide for use:

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

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation: National Data Standards for Injury Surveillance Advisory Group

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes External cause - human intent, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.35 KB)

Implementation in Data Set Specifications:

Injury surveillance DSS Health, Superseded 05/02/2008

Injury surveillance DSS Health, Standard 05/02/2008

Injury surveillance NMDS Health, Superseded 03/05/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Injury surveillance NMDS Health, Superseded 07/12/2005

Family name

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (name)—family name, text X[X(39)]
Synonymous names:	Surname; Last name
METeOR identifier:	286953
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 20/06/2005
Definition:	That part of a name a person usually has in common with some other members of his/her family, as distinguished from his/her given names, as represented by text.
Data Element Concept:	Person (name)—family name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	X[X(39)]
Maximum character length:	40

Data element attributes

Collection and usage attributes

Guide for use:	The agency or establishment should record the person's full **family** name on their information systems. National Community Services Data Dictionary specific: In instances where there is uncertainty about which name to record for a person living in a remote Aboriginal or Torres Strait Islander community, Centrelink follows the practice of recording the Indigenous person's name as it is first provided to Centrelink. Or, where proof of identity is required, as the name is recorded on a majority of the higher point scoring documents that are produced as proof of identity.
Collection methods:	This metadata item should be recorded for all persons who receive services from or are of interest to an organisation. For the purposes of positive identification, it may also be recorded for providers of those services who are individuals. Mixed case should be used. Family name should be recorded in the format preferred by the person. The format should be the same as that written by the person on a (pre) registration form or in the same format as that printed on an identification card, such as Medicare card, to ensure consistent collection of name data. It is acknowledged that some people use more than one family name (e.g. formal name, birth name, married/maiden name, tribal name) depending on the circumstances. Each name should be recorded against the appropriate Name type (see

Comments).

A person is able to change his or her name by usage in all States and Territories of Australia with the exception of Western Australia, where a person may only change his or her name under the Change of Name Act. Care should be taken when recording a change of name for a minor. Ideally, the name recorded for the minor should be known to both of his/her parents, so the minor's records can be retrieved and continuity of care maintained, regardless of which parent accompanies the minor to the agency or establishment.

A person should generally be registered using their preferred name as it is more likely to be used in common usage and on subsequent visits to the agency or establishment. The person's preferred name may in fact be the name on their Medicare card. The Person name type metadata item can be used to distinguish between the different types of names that may be used by the person. The following format may assist with data collection:

What is your family name?

_____

Are you known by any other family names that you would like recorded? If so, what are they

_____

Please indicate, for each name above, the 'type' of family name that is to be recorded:

(a) Medicare card name (if different to preferred name).

(b) Alias (any other name that you are known by). Whenever a person informs the agency or establishment of a change of family name (e.g. following marriage or divorce), the former name should be recorded as an alias name. A full history of names should be retained. e.g. 'Mary Georgina Smith' informs the hospital that she has been married and changed her family name to 'Jones'. Record 'Jones' as her preferred family name and record 'Smith' as an alias name.

Hyphenated family names:

Sometimes persons with hyphenated family names use only one of the two hyphenated names. It is useful to record each of the hyphenated names as an alias. If the person has a hyphenated family name, e.g. 'Wilson-Phillips' record 'Wilson-Phillips' in the preferred family name field and record 'Wilson' and 'Phillips' separately as alias family names.

Punctuation:

If special characters form part of the family name they should be included, e.g. hyphenated names should be entered with a hyphen.

Examples:

- hyphen, e.g. Wilson-Phillips

Do not leave a space before or after a hyphen, i.e. between the last letter of 'Wilson' and the hyphen, nor a space between the hyphen and the first letter of 'Phillips'.

- apostrophe, e.g. O'Brien, D'Agostino

Do not leave a space before or after the apostrophe, i.e. between the 'O' and the apostrophe, nor a space between the apostrophe and 'Brien'.

- full stop, e.g. St. John, St. George

Do not leave a space before a full stop, i.e. between 'St' and the

full stop. Do leave a space between the full stop and 'John'.

- space, e.g. van der Humm, Le Brun, Mc Donald

If the health care client has recorded their family name as more than one word, displaying spaces in between the words, record their family name in the same way leaving one space between each word.

Registered unnamed newborn babies:

When registering a newborn, use the mother's family name as the baby's family name unless instructed otherwise by the mother. Record unnamed babies under the newborn Name type.

Persons with only one name:

Some people do not have a family name and a given name, they have only one name by which they are known. If the person has only one name, record it in the 'Family name' field and leave the 'Given name' field blank.

Registering an unidentified person:

The default for unknown family name, should be unknown in all instances and the name recorded as an alias name. Don't create a 'fictitious' family name such as 'Doe' as this is an actual family name. When the person's name becomes known, record it as the preferred family name and do not overwrite the alias name of unknown.

Registering health care clients from disaster sites:

Persons treated from disaster sites should be recorded under the alias Name Type. Local business rules should be developed for consistent recording of disaster site person details.

Care should be taken not to use identical dummy data (family name, given name, date of birth, sex) for two or more persons from a disaster site.

If the family name needs to be shortened:

If the length of the family name exceeds the length of the field, truncate the family name from the right (that is, dropping the final letters). Also, the last character of the name should be a hash (#) to identify that the name has been truncated.

Use of incomplete names or fictitious names:

Some health care facilities permit persons to use a pseudonym (fictitious or partial name) in lieu of their full or actual name. It is recommended that the person be asked to record both the pseudonym (Alias name) in addition to the person's Medicare card name.

Baby for **adoption**:

The word adoption should not be used as the family name, given name or alias for a newborn baby. A newborn baby that is for adoption should be registered in the same way that other newborn babies are registered. However, if a baby born in the hospital is subsequently adopted, and is admitted for treatment as a child, the baby is registered under their adopted (current) name, and the record should not be linked to the birth record. This should be the current practice. Any old references to adoption in client registers (for names) should also be changed to unknown. Contact your State or Territory adoption information service for further information.

Prefixes:

Where a family name contains a prefix, such as one to indicate

that the person is a widow, this must be entered as part of the 'Family name' field. When widowed, some Hungarian women add 'Ozvegy' (abbreviation is 'Ozy') before their married family name, e.g. 'Mrs Szabo' would become 'Mrs Ozy Szabo'. That is, 'Mrs Szabo' becomes an alias name and 'Mrs Ozy Szabo' becomes the preferred name.

Ethnic Names:

The Centrelink publication, Naming Systems for Ethnic Groups, provides the correct coding for ethnic names.

Misspelled family name:

If the person's family name has been misspelled in error, update the family name with the correct spelling and record the misspelled family name as an alias name. Recording misspelled names is important for filing documents that may be issued with previous versions of the person's name. Discretion should be used regarding the degree of recording that is maintained.

Comments:

Often people use a variety of names, including legal names, married/maiden names, nicknames, assumed names, traditional names, etc. Even small differences in recording - such as the difference between MacIntosh and McIntosh - can make record linkage impossible. To minimise discrepancies in the recording and reporting of name information, agencies or establishments should ask the person for their full (formal) 'Given name' and 'Family name'. These may be different from the name that the person may prefer the agency or establishment workers to use in personal dealings. Agencies or establishments may choose to separately record the preferred names that the person wishes to be used by agency or establishment workers. In some cultures it is traditional to state the family name first. To overcome discrepancies in recording/reporting that may arise as a result of this practice, agencies or establishments should always ask the person to specify their first given name and their family name or surname separately. These should then be recorded as 'Given name' and 'Family name' as appropriate, regardless of the order in which they may be traditionally given.

National Community Services Data Dictionary specific:

Selected letters of the family name in combination with selected letters of the given name, date of birth and sex, may be used for record linkage for statistical purposes only.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Standards Australia

Origin:

National Health Data Committee

National Community Services Data Committee

Commonwealth Department of Health and Family Services 1998. Home and Community Care Data Dictionary Version 1.0. Canberra: DHFS Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Reference documents:

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

Relational attributes

Related metadata references:

See also Person (name)—given name, text [X(40)] Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 20/06/2005

Supersedes Person (name)—family name, text X[X(39)] Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005

Is used in the formation of Person—letters of given name, text XX Community services, Standard 27/03/2007

Is used in the formation of Person—letters of family name, text XXX Community services, Standard 27/03/2007

Implementation in Data Set Specifications:

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

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

Health care client identification DSS Health, Standard 04/05/2005

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

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

Information specific to this data set:
When used for the purpose of positive identification or contact, agencies or establishments that collect Family name should also collect Person name type.

Fasting status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health service event—fasting indicator, code N
METeOR identifier:	302941
Registration status:	Health, Standard 21/09/2005
Definition:	Whether the patient was fasting at the time of an examination, test, investigation or procedure, as represented by a code.
Data Element Concept:	Health service event—fasting indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes: Record if the patient is fasting at the time of an examination, test, investigation or procedure. CODE 2 No: Record if the patient is not fasting at the time of an examination, test, investigation or procedure.
Comments:	In settings where the monitoring of a person's health is ongoing and where management can change over time (such as general practice), the service contact date should be recorded.

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group Cardiovascular Data Working Group

Relational attributes

Related metadata references:	Supersedes Health service event—fasting status, code N Health, Superseded 21/09/2005 Is used in the formation of Person—low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N Health, Standard 01/03/2005

Implementation in Data Set Specifications:	Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006 Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007 Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007 Diabetes (clinical) DSS Health, Standard 21/09/2005

Feedback collection indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—feedback collection indicator, yes/no code N
METeOR identifier:	290438
Registration status:	Health, Standard 05/12/2007
Definition:	Whether feedback relating to services and service delivery is actively and routinely collected from clients and staff within a service provider organisation, as represented by a code.
Data Element Concept:	Service provider organisation—feedback collection indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

The active and routine collection of feedback from clients and/or staff means that, as a matter of routine, the agency initiates and implements feedback mechanisms and does not rely on mechanisms such as ad hoc comments, ad hoc questionnaires, informal debriefing sessions, or similar casual arrangements.

Active mechanisms include the use of periodic questionnaires that are implemented through either face-to-face interviews, by telephone or by mail, focus groups aimed at collecting feedback from the participants, established debriefing sessions, or other routine procedures the agency has in place to collect feedback.

CODE 1 Yes
The service provider organisation actively and routinely collects feedback relating to services and service delivery from clients and staff within the service provider organisation. If feedback is actively and routinely collected from clients only or staff only, this should be recorded as 'No' (Code 2).

CODE 2 No
The service provider organisation does not actively and routinely collect feedback relating to services and service delivery from clients and staff within the service provider organisation.

Collection methods: Record only one code.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

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

Information specific to this data set:
This information is required for the calculation of the national palliative care performance indicator number 3: 'The proportion of palliative care agencies, within their setting of care, that actively collect feedback from patients/consumers and staff (within the workforce) relating to services and service delivery'.

Feedback collection method

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—feedback collection method, code N
METeOR identifier:	290476
Registration status:	Health, Standard 05/12/2007
Definition:	The method the service provider organisation employs to actively and routinely collect feedback on services and service delivery, as represented by a code.
Data Element Concept:	Service provider organisation—feedback collection method

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Questionnaire - periodic face-to-face interview
2	Questionnaire - face-to-face interview on exit
3	Questionnaire - periodic telephone interview
4	Questionnaire - telephone interview on exit
5	Questionnaire - periodic written survey
6	Questionnaire - written survey on exit
7	Feedback focus group
8	Other

Data element attributes

Collection and usage attributes

Guide for use:

The active and routine collection of feedback means that, as a matter of routine, the agency initiates and implements feedback methods and does not rely on mechanisms such as ad hoc comments, ad hoc questionnaires, informal debriefing sessions, or similar casual arrangements.

Active methods include the use of periodic questionnaires that are implemented through either face-to-face interviews, by telephone or by mail, focus groups aimed at collecting feedback from the participants, established debriefing sessions, or other routine procedures the agency has in place to collect feedback.

The aim of the method used must be to collect feedback on services and service delivery.

'Periodic' may mean at set intervals or at (a) specified points in time during the service episode.

'On exit' refers to the closure of the service episode (for clients

or related people), or (for staff) the time at which the staff member ceases to be employed by the agency.

CODE 7 Feedback focus group

An in-depth qualitative interview with a small number of persons, held specifically to collect feedback from the participants.

Collection methods: More than one code can be recorded.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

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

Conditional obligation:
Recorded when the data element *Service provider organisation – feedback collection indicator, yes/no code N* value is 'yes' (code 1).

Fibrinolytic drug used

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—fibrinolytic drug administered, code N
METeOR identifier:	285079
Registration status:	Health, Standard 04/06/2004
Definition:	The fibrinolytic drug used, as represented by a code.
Data Element Concept:	Person—fibrinolytic drug administered

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Streptokinase
2	t-PA (Tissue Plasminogen Activator) (Alteplase)
3	r-PA (Reteplase)
4	TNK t-PA (Tenecteplase)

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Fibrinolytic drug used, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.04 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005
	Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005
	Information specific to this data set: For Acute coronary syndrome (ACS) reporting, this data element pertains to the administering of fibrinolytic therapy drugs at any time point during this current event.

Fibrinolytic therapy status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—fibrinolytic therapy status, code NN
METeOR identifier:	285087
Registration status:	Health, Standard 04/06/2004
Definition:	The person's fibrinolytic therapy status, as represented by a code.
Data Element Concept:	Person—fibrinolytic therapy status

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
10	Given
21	Not given - therapy not indicated
22	Not given - patient refusal
23	Not given - previous haemorrhagic stroke at any time; other strokes or cerebrovascular events within 1 year
24	Not given - known intracranial neoplasm
25	Not given - active or recent (within 2 to 4 weeks) internal bleeding (does not include menses)
26	Not given - suspected aortic dissection
27	Not given - severe uncontrolled hypertension on presentation (blood pressure >180 mmHg systolic and/or 110 mmHg diastolic). Note: This could be an absolute contraindication in low-risk patients with MI.
28	Not given - history of prior cerebrovascular accident or known intracerebral pathology not covered in 2.3 & 2.4 contraindications
29	Not given - current use of anticoagulants in therapeutic doses (INR greater than or equal to 2); known bleeding diathesis
30	Not given - recent trauma (within 2 to 4 weeks), including head trauma, traumatic or prolonged (greater than 10 minutes) CPR, or major surgery (less than 3 weeks)
31	Not given - pregnancy
32	Not given - other

Supplementary values:

90	Not stated/inadequately described

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: CODES 23, 24, 25, 26, 27, 28, 29, 30 and 31

More than one code may recorded for the following codes: 23, 24, 25, 26, 27, 28, 29, 30 and 31.

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Steward: The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references: Supersedes Fibrinolytic therapy status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.97 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005

Information specific to this data set:

For Acute coronary syndrome (ACS) reporting, to be collected with the data elements Triage—triage date, DDMMYYYY, Triage—triage time, hhmm, Person—risk stratum, code N.

This data element pertains to the administering of fibrinolytic therapy drugs at any time point during this current event.

First day of the last menstrual period

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Pregnancy—first day of the last menstrual period, date DDMMYYYY
METeOR identifier:	270038
Registration status:	Health, Standard 01/03/2005
Definition:	Date of the first day of the mother's last menstrual period (LMP).
Data Element Concept:	Pregnancy—first day of the last menstrual period

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	If the first day is unknown, it is unnecessary to record the month and year (i.e. record 99999999).
Comments:	The first day of the LMP is required to estimate gestational age, which is a key outcome of pregnancy and an important risk factor for neonatal outcomes. Although the date of the LMP may not be known, or may sometimes be erroneous, estimation of gestational age based on clinical assessment may also be inaccurate. Both methods of assessing gestational age are required for analysis of outcomes.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes First day of the last menstrual period, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.56 KB) Is used in the formation of Female (pregnant)—estimated gestational age, total weeks NN Health, Standard 01/03/2005

Floor/level number (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—floor/level identifier, [NNNA]
METeOR identifier:	270029
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	The unique identifier for the floor/level where a person can be located.
Data Element Concept:	Person (address)—floor/level identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	[NNNA]
Maximum character length:	4

Data element attributes

Collection and usage attributes

Guide for use:	Floor/level number and suffix are both optional. The Floor/level number must be recorded with its corresponding Floor/level type. Some Floor/level numbers may be followed by an alphabetic suffix. Examples of Floor/level identification: FL 1A L 3 LG A
Collection methods:	Do not leave a space between the number and alpha suffix. To be collected in conjunction with Floor/level type.

Source and reference attributes

Origin:	Health Data Standards Committee Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Supersedes Floor/level number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.91 KB) Is used in the formation of Person (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005 Is used in the formation of Person (address)—health address line, text [X(180)] Health, Superseded 04/05/2005
Implementation in Data Set Specifications:	Health care client identification DSS Health, Standard 04/05/2005

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

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

Floor/level number (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—floor/level identifier, [NNNA]
METeOR identifier:	290264
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The unique identifier for floor/level, where an organisation can be located.
Data Element Concept:	Service provider organisation (address)—floor/level identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	[NNNA]
Maximum character length:	4

Data element attributes

Collection and usage attributes

Guide for use:	Floor/level number and suffix are both optional. The Floor/level number must be recorded with its corresponding Floor/level type. Some Floor/level numbers may be followed by an alphabetic suffix. Examples of Floor/level identification: FL 1A L 3 LG A
Collection methods:	Do not leave a space between the number and alpha suffix. To be collected in conjunction with Floor/level type.

Source and reference attributes

Origin:	Health Data Standards Committee Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Is used in the formation of Service provider organisation (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005
Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Floor/level type (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—floor/level type, code A[A]
METeOR identifier:	270024
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	The type of floor/level where a person can be located, as represented by a code.
Data Element Concept:	Person (address)—floor/level type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
B	Basement
FL	Floor
G	Ground
L	Level
LG	Lower Ground
M	Mezzanine
UG	Upper Ground

Data element attributes

Collection and usage attributes

Guide for use:	Some floor/level identification may require the Floor/level type plus a Floor/level number to be recorded.
Collection methods:	To be collected in conjunction with Floor/level number where applicable. Some Floor/level type entries will often have no corresponding number e.g. Basement, Ground, Lower ground, Mezzanine and Upper ground.

Source and reference attributes

Origin:	Health Data Standards Committee Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Supersedes Floor/level type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.47 KB) Is used in the formation of Person (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005

	Is used in the formation of Person (address)—health address line, text [X(180)] Health, Superseded 04/05/2005
Implementation in Data Set Specifications:	Health care client identification DSS Health, Standard 04/05/2005
	Health care provider identification DSS Health, Superseded 04/07/2007
	Health care provider identification DSS Health, Standard 04/07/2007

Floor/level type (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—floor/level type, code A[A]
METeOR identifier:	290245
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The type of floor/level where an organisation can be located, as represented by a code.
Data Element Concept:	Service provider organisation (address)—floor/level type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
B	Basement
FL	Floor
G	Ground
L	Level
LG	Lower Ground
M	Mezzanine
UG	Upper Ground

Data element attributes

Collection and usage attributes

Collection methods:	To be collected in conjunction with Floor/level number where applicable. Some Floor/level type entries will often have no corresponding number e.g. Basement, Ground, Lower ground, Mezzanine and Upper ground.

Source and reference attributes

Origin:	Health Data Standards Committee Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Is used in the formation of Service provider organisation (address)—address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005
Implementation in Data Set Specifications:	Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Standard 04/07/2007

Foot deformity

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—foot deformity indicator, code N
METeOR identifier:	302449
Registration status:	Health, Standard 21/09/2005
Definition:	Whether a deformity is present on either foot, as represented by a code.
Data Element Concept:	Person—foot deformity indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes: Record if a foot deformity is present on either foot. CODE 2 No: Record if no foot deformity is present on either foot. Common deformities include claw toes, pes cavus, hallux valgus, hallux rigidus, hammer toe, Charcot foot and nail deformity.
Collection methods:	Both feet to be examined for the presence of foot deformity.
Comments:	Foot deformities are associated with high mechanical pressure on the overlying skin that lead to ulceration in the absence of protective pain sensation and when shoes are unsuitable. Limited joint mobility is often present, with displaced plantar fat pad and more prominent metatarsal heads.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary
Reference documents:	Lesley V Campbell, Antony R Graham, Rosalind M Kidd, Hugh

F Molloy, Sharon R O'Rourke and Stephen Colagiuri: The Lower Limb in People With Diabetes; Content 1997/98 Australian Diabetes Society.

Edmonds M, Boulton A, Buckenham T, et al. Report of the Diabetic Foot and Amputation Group. Diabet Med 1996; 13: S27 - 42.

Reiber GE. Epidemiology of the diabetic foot. In: Levin ME, O'Neal LW, Bowker JH, editors. The diabetic foot. 5th ed. St Louis: Mosby Year Book, 1993; 1 - 5.

Most RS, Sinnock P. The epidemiology of lower limb extremity amputations in diabetic individuals. Diabetes Care 1983; 6: 87 - 91.

Therapeutic Guidelines Limited (05.04.2002) Management plan for diabetes.

Relational attributes

Related metadata references:

Supersedes Person—foot deformity status, code N Health, Superseded 21/09/2005

Implementation in Data Set Specifications:

Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

Foot deformities are frequently the result of diabetic motor neuropathy and diabetic foot disease is the most common cause of hospitalisation in people with diabetes.

Diabetic foot complications are common in the elderly, and amputation rates increase with age: by threefold in those aged 45 - 74 years and sevenfold over 75 years. In people with diabetes, amputations are 15 times more common than in people without diabetes and 50% of all amputations occur in people with diabetes (Epidemiology of the diabetic foot; Report of the Diabetic Foot and Amputation Group). All patients with diabetes mellitus should be instructed about proper foot care in an attempt to prevent ulcers. Feet should be kept clean and dry at all times. Patients with neuropathy should not walk barefoot, even in the home. Properly fitted shoes are essential.

Specialised foot clinics appear to decrease further episodes of foot ulceration and decrease hospital admissions for amputations.

Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus recommendations include:

- feet should be examined every 6 months or at every visit if high risk foot or active foot problem.
- refer to specialists experienced in the care of the diabetic foot if infection or ulceration is present.
- ensure that patients with 'high-risk foot' or an active foot problem receive appropriate care from specialists and podiatrists expert in the treatment of diabetic foot problems.
- to identify the 'high-risk foot' as indicated by a past history of foot problems, especially ulceration, and/or the presence of Peripheral neuropathy
- assessment outcome, peripheral vascular disease, or foot deformity or history of previous ulceration.

Foot lesion (active)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—foot lesion indicator (active), code N
METeOR identifier:	302437
Registration status:	Health, Standard 21/09/2005
Definition:	Whether an individual has an active foot lesion, other than an ulcer, on either foot, as represented by a code.
Data Element Concept:	Person—foot lesion indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes: Record if current active foot lesion other than ulceration is present on either foot. CODE 2 No: Record if no current active foot lesion other than ulceration is present on either foot. The following entities would be included: fissures, infections, inter-digital maceration, corns, calluses and nail dystrophy.
Collection methods:	Assess whether the individual has an active foot lesion on either foot.

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Person—foot lesion status (active), code N Health, Superseded 21/09/2005
Implementation in Data Set	Diabetes (clinical) DSS Health, Standard 21/09/2005

Specifications:

Information specific to this data set:
Early detection and appropriate management of the 'high risk foot' and active foot problems can reduce morbidity, hospitalisation and amputation in people with diabetes.

Foot ulcer (history)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—foot ulcer indicator (history), code N
METeOR identifier:	302819
Registration status:	Health, Standard 21/09/2005
Definition:	Whether person has a previous history of ulceration on either foot, as represented by a code.
Data Element Concept:	Person—foot ulcer indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes: Record if person has a previous history of ulceration on either foot. CODE 2 No: Record if person has no previous history of ulceration on either foot.
Collection methods:	Ask the individual if he/she a previous history of foot ulceration. Alternatively obtain this information from appropriate documentation.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references:	Supersedes Person—foot ulcer history status, code N Health, Superseded 21/09/2005
Implementation in Data Set Specifications:	Diabetes (clinical) DSS Health, Standard 21/09/2005 *Information specific to this data set:*

Past history of foot ulceration, peripheral neuropathy and foot deformities have been associated with increased risk of foot ulceration and lower limb amputation for patients who suffer from diabetes. The aim is to identify the 'high-risk foot' as indicated by a past history of foot problems, especially ulceration.

Following the Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus, individuals with a 'high-risk foot' or a significant active foot problem should be examined every six months or at every visit.

Assessment:

- ask patient about previous foot problems, neuropathic symptoms, rest pain and intermittent claudication
- inspect the feet (whole foot, nails, between the toes) to identify active foot problems and the 'high-risk foot'
- assess footwear
- check peripheral pulses
- examine for neuropathy by testing reflexes and sensation preferably using tuning fork, 10 g monofilament and/or biothesiometer.

Foot ulcer (current)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—foot ulcer indicator (current), code N
METeOR identifier:	302445
Registration status:	Health, Standard 21/09/2005
Definition:	Whether an individual has a current foot ulcer on either foot, as represented by a code.
Data Element Concept:	Person—foot ulcer indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes: Record if a foot ulcer is currently present on either foot. CODE 2 No: Record if a foot ulcer is not currently present on either foot.
Collection methods:	Access whether the individual has a current foot ulcer on either foot. Assessment • ask the patient about previous or current foot problems, neuropathic symptoms, rest pain and intermittent claudication; • inspect the feet (whole foot, nails, between the toes) to identify active foot problems and the 'high-risk foot'; • assess footwear; • check peripheral pulses; • examine for neuropathy by testing reflexes and sensation preferably using tuning fork, 10 g monofilament and/or biothesiometer.
Comments:	Foot ulcer is usually situated on the edge of the foot or toes

because blood supply is the poorest at these sites. In a purely vascular ulcer, nerve function is normal and sensation is intact, hence vascular ulcers are usually painful.

Foot ulcers require urgent care from an interdisciplinary team, which may include a general practitioner, podiatrist, endocrinologist physician, nurse or surgeon.

Source and reference attributes

Submitting organisation: National diabetes data working group

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

Reference documents: The Diabetic Foot Vol 3 No 4. Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus.

Relational attributes

Related metadata references: Supersedes Person—foot ulcer status (current), code N Health, Superseded 21/09/2005

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Standard 21/09/2005

Information specific to this data set:

The development of ulcers of the feet and lower extremities is a special problem in the diabetic patient, and appears to be due primarily to abnormal pressure distribution secondary to diabetic neuropathy.

Diabetic foot ulceration is a serious problem and the lack of pain does not mean that the ulcer can be ignored or neglected. The absence of pain is very common in people with diabetes due to peripheral neuropathy.

All patients with diabetes mellitus should be instructed about proper foot care in an attempt to prevent ulcers. Feet should be kept clean and dry at all times. Patients with neuropathy should not walk barefoot, even in the home. Properly fitted shoes are essential.

Early detection and appropriate management of the 'high-risk foot' and current foot ulceration can reduce morbidity, hospitalisation and amputation in people with diabetes.

Formal community support access status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—formal community support access indicator (current), code N
METeOR identifier:	270169
Registration status:	Health, Standard 01/03/2005
Definition:	Whether a person is currently accessing a formal community support service or services, as represented by a code.
Data Element Concept:	Person—formal community support access indicator

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Currently accessing
	2	Currently not accessing
Supplementary values:	9	Not known/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1:

The person is currently accessing at least one paid community support service (i.e. meals on wheels, home help, in-home respite, service packages, district nursing services, etc).

CODE 2:

The person is not currently accessing any paid community support service or services.

CODE 9:

The person's current status with regards to accessing community support services is not known or inadequately described for more specific coding.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Relational attributes

Related metadata references: Supersedes Formal community support access status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.54 KB)

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

Cardiovascular disease (clinical) DSS Health, Superseded

04/07/2007

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

Full-time equivalent staff (mental health)—all staff

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (mental health)—full-time equivalent staff (paid), total N[NNN{.N}]
METeOR identifier:	296553
Registration status:	Health, Standard 08/12/2004
Definition:	The aggregate full-time equivalent staff units paid for all staffing categories within a mental health establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Guide for use:	The total is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. Full-time equivalent staff units are the on-job hours paid for (including overtime) and hours of paid leave of any type for a staff member (or contract employee where applicable) divided by the number of ordinary-time hours normally paid for a full-time staff member when on the job (or contract employee where applicable) under the relevant award or agreement for the staff member (or contract employee occupation where applicable). Hours of unpaid leave are to be excluded. Contract staff employed through an agency are included where the contract is for the supply of labour (e.g. nursing) rather than of products (e.g. photocopier maintenance). In the former case, the contract would normally specify the amount of labour supplied and could be reported as full-time equivalent units.
Collection methods:	Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items. Where staff provide services to more than one hospital (for Public hospitals NMDS) or service unit (for Mental health establishments NMDS), full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each

(salary costs should be apportioned on the same basis).

Comments: This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Is formed using Establishment—full-time equivalent staff (paid) (other personal care staff), average N[NNN{.N}] Health, Standard 01/03/2005

Is formed using Establishment—full-time equivalent staff (paid) (domestic and other staff), average N[NNN{.N}] Health, Standard 01/03/2005

Is formed using Establishment—full-time equivalent staff (paid) (administrative and clerical staff), average N[NNN{.N}] Health, Standard 01/03/2005

Is formed using Establishment—full-time equivalent staff (paid) (enrolled nurses), average N[NNN{.N}] Health, Standard 01/03/2005

Is formed using Establishment—full-time equivalent staff (paid) (registered nurses), average N[NNN{.N}] Health, Standard 01/03/2005

Is formed using Establishment—full-time equivalent staff (paid) (consumer consultants), average N[NNN{.N}] Health, Standard 08/12/2004

Is formed using Establishment—full-time equivalent staff (paid) (carer consultants), average N[NNN{.N}] Health, Standard 08/12/2004

Is formed using Establishment—full-time equivalent staff (paid) (salaried medical officers), average N[NNN{.N}] Health, Standard 01/03/2005

Is formed using Establishment—full-time equivalent staff (paid) (diagnostic and health professionals), average N[NNN{.N}] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health,

Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Obligation condition: Must be supplied if the sub-categories cannot be supplied. Can also be supplied if the sub-categories are supplied.

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

NOTE: Data for the sub-categories of Salaried medical officers and diagnostic and health professionals, and the categories of Carer consultants and Consumer consultants to be reported for Mental health establishments NMDS only.

Full-time equivalent staff—administrative and clerical staff

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (administrative and clerical staff), average N[NNN{.N}]
METeOR identifier:	270496
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **administrative and clerical staff** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (administrative and clerical staff)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	Staff engaged in administrative and clerical duties. Medical staff and nursing staff, diagnostic and health professionals and any domestic staff primarily or partly engaged in administrative and clerical duties are excluded. Civil engineers and computing staff are included in this metadata item. The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. If under the relevant award of agreement a full-time employee is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time employee who works 64 hours is 0.8. If a full-time employee under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25. Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items. Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).
Comments:	This metadata item was amended during 1996-97. Until then,

both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.88 KB)

Is used in the formation of Establishment (mental health)—full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Implementation in Data Set Specifications: Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Full-time equivalent staff—average

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid), average N[NNN{.N}]
METeOR identifier:	270543
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all staffing categories within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:

Calculated by adding the full-time equivalents for each staffing category listed below:

C1.1 Salaried medical officers

C1.2 Registered nurses

C1.3 Enrolled nurses

C1.4 Student nurses

C1.5 Trainee/pupil nurses

C1.6 Other personal care staff

C1.7 Diagnostic and health professionals

C1.8 Administrative and clerical staff

C1.9 Domestic and other staff

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

If under the relevant award of agreement a full-time nurse is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time nurse who works 64 hours is 0.8. If a full-time nurse under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25.

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment,

full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

Full-time equivalent staff units are the on-job hours paid for (including overtime) and hours of paid leave of any type for a staff member (or contract employee where applicable) divided by the number of ordinary-time hours normally paid for a full-time staff member when on the job (or contract employee where applicable) under the relevant award or agreement for the staff member (or contract employee occupation where applicable). Hours of unpaid leave are to be excluded.

Contract staff employed through an agency are included where the contract is for the supply of labour (e.g. nursing) rather than of products (e.g. photocopier maintenance). In the former case, the contract would normally specify the amount of labour supplied and could be reported as full-time equivalent units.

Comments: This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.88 KB)

Implementation in Data Set Specifications: Community mental health establishments NMDS 2004-2005 Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

Full-time equivalent staff—carer consultants

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (carer consultants), average N[NNN{.N}]
METeOR identifier:	296498
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of full-time equivalent staff units paid for all **carer consultants** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (carer consultants)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	Carer consultants are persons employed (or engaged via contract) on a part-time or full-time paid basis to represent the interests of carers and advocate for their needs. This implies the person received a salary or contract fee on a regular basis. It does not refer to arrangements where the carer only received reimbursements of expenses or occasional sitting fees for attendance at meetings. The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items. Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).
Comments:	This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Is used in the formation of Establishment (mental health)—full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Implementation in Data Set Specifications: Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Full-time equivalent staff—consultant psychiatrists and psychiatrists

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (consultant psychiatrists and psychiatrists), average N[NNN{.N}]
METeOR identifier:	287509
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of full-time equivalent staff units paid for all **consultant psychiatrists and psychiatrists** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (consultant psychiatrists and psychiatrists)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	Medical officers who are registered to practice psychiatry under the relevant state or territory Medical Registration Board; or who are fellows of the Royal Australian and New Zealand College of Psychiatrists or registered with Health Insurance Commission as a specialist in Psychiatry. The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure metadata items. Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).
Comments:	This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments

and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Full-time equivalent staff—consumer consultants

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (consumer consultants), average N[NNN{.N}]
METeOR identifier:	296496
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of full-time equivalent staff units paid for all **consumer consultants** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (consumer consultants)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	Consumer consultants are persons employed (or engaged via contract) on a part-time or full-time paid basis to represent the interests of consumers and advocate for their needs. This implies the person received a salary or contract fee on a regular basis. It does not refer to arrangements where the consumer only received reimbursements of expenses or occasional sitting fees for attendance at meetings. The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items. Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).
Comments:	This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Is used in the formation of Establishment (mental health)—full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Implementation in Data Set Specifications: Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Full-time equivalent staff—diagnostic and health professionals

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (diagnostic and health professionals), average N[NNN{.N}]
METeOR identifier:	270495
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **diagnostic and health professionals** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (diagnostic and health professionals)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	Qualified staff (other than qualified medical and nursing staff) engaged in duties of a diagnostic, professional or technical nature (but also including diagnostic and health professionals whose duties are primarily or partly of an administrative nature). This metadata item includes all allied health professionals and laboratory technicians (but excludes civil engineers and computing staff). This metadata item includes full-time equivalent staff units of occupational therapists, social workers, psychologists, and other diagnostic and health professionals. The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. If under the relevant award of agreement a full-time employee is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time employee who works 64 hours is 0.8. If a full-time employee under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25. Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

Comments: This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.88 KB)

Is used in the formation of Establishment (mental health)—full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Implementation in Data Set Specifications: Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Full-time equivalent staff—domestic and other staff

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (domestic and other staff), average N[NNN{.N}]
METeOR identifier:	270498
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **domestic and other staff** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (domestic and other staff)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:

Domestic staff are staff engaged in the provision of food and cleaning services including domestic staff primarily engaged in administrative duties such as food services manager. Dieticians are excluded.

This metadata item also includes all staff not elsewhere included (primarily maintenance staff, trades people and gardening staff).

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

If under the relevant award of agreement a full-time employee is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time employee who works 64 hours is 0.8. If a full-time employee under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25.

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

Comments: This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.88 KB)
Is used in the formation of Establishment (mental health)—full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Implementation in Data Set Specifications: Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Full-time equivalent staff—enrolled nurses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (enrolled nurses), average N[NNN{.N}]
METeOR identifier:	270497
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **enrolled nurses** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (enrolled nurses)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	Enrolled nurses are second level nurses who are enrolled in all states except Victoria where they are registered by the state registration board to practise in this capacity. Includes general enrolled nurse and specialist enrolled nurse (e.g. mothercraft nurses in some states). The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. If under the relevant award of agreement a full-time nurse is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time nurse who works 64 hours is 0.8. If a full-time nurse under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25. Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items. Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).
Comments:	This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as

surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.88 KB)

Is used in the formation of Establishment (mental health)—full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Implementation in Data Set Specifications: Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Full-time equivalent staff—occupational therapists

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (occupational therapists), average N[NNN{.N}]
METeOR identifier:	287603
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of full-time equivalent staff units paid for all **occupational therapists** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (occupational therapists)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	Persons who have completed a course of recognised training and are eligible for membership of the Australian Association of Occupational Therapists. The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items. Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).
Comments:	This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Occupational therapists are included when calculating all diagnostic and health professionals.

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Full-time equivalent staff—other diagnostic and health professionals

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (other diagnostic and health professionals), average N[NNN{.N}]
METeOR identifier:	287611
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of full-time equivalent staff units paid for all **other diagnostic and health professionals** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (other diagnostic and health professionals)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	Includes qualified staff (other than qualified medical or nursing staff) engaged in duties of a diagnostic, professional or technical nature. This metadata item covers all allied health professionals and laboratory technicians (but excludes civil engineers and computing staff). The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items. Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).
Comments:	This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments

and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Full-time equivalent staff—other medical officers

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (other medical officers), average N[NNN{.N}]
METeOR identifier:	287531
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of full-time equivalent staff units paid for all **other medical officers** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (other medical officers)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	Medical officers employed or engaged by the organisation who are neither registered as psychiatrists within the state or territory nor formal trainees within the Royal Australian and New Zealand College of Psychiatrists Postgraduate Training Program. The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure metadata items. Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).
Comments:	This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Other medical officers are included when calculating salaried medical officers.

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Full-time equivalent staff—other personal care staff

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (other personal care staff), average N[NNN{.N}]
METeOR identifier:	270171
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **other personal care staff** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (other personal care staff)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:

This metadata item includes attendants, assistants or home assistance, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants engaged primarily in the provision of personal care to patients or residents, who are not formally qualified or undergoing training in nursing or allied health professions

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

If under the relevant award of agreement a full-time employee is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time employee who works 64 hours is 0.8. If a full-time employee under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned

between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

Comments: This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Steward: Australian Bureau of Statistics (ABS)

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.88 KB)

Is used in the formation of Establishment (mental health)—full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Implementation in Data Set Specifications: Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Full-time equivalent staff—psychiatry registrars and trainees

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (psychiatry registrars and trainees), average N[NNN{.N}]
METeOR identifier:	287529
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of full-time equivalent staff units paid for all **psychiatry registrars and trainees** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (psychiatry registrars and trainees)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	Medical officers who are formal trainees within the Royal Australian and New Zealand College of Psychiatrists Postgraduate Training Program. The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items. Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).
Comments:	This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Psychiatry registrars and trainees are included when calculating salaried medical officers.

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Full-time equivalent staff—psychologists

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (psychologists), average N[NNN{.N}]
METeOR identifier:	287609
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of full-time equivalent staff units paid for all **psychologists** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (psychologists)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	Persons who are registered as psychologists with the relevant state and territory registration board. The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items. Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).
Comments:	This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Relational attributes

Implementation in Data Set Specifications:	Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 *Implementation start date:* 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

Psychologists are included when calculating diagnostic and health professionals.

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Full-time equivalent staff—registered nurses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (registered nurses), average N[NNN{.N}]
METeOR identifier:	270500
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **registered nurses** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (registered nurses)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. If under the relevant award of agreement a full-time nurse is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time nurse who works 64 hours is 0.8. If a full-time nurse under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25. Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items. Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).
Comments:	This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.88 KB)

Is used in the formation of Establishment (mental health)—full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Implementation in Data Set Specifications: Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Full-time equivalent staff—salaried medical officers

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (salaried medical officers), average N[NNN{.N}]
METeOR identifier:	270494
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **salaried medical officers** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (salaried medical officers)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:

Medical officers employed by the hospital on a full time or part time salaried basis. This excludes visiting medical officers engaged on an honorary, sessional or fee for service basis.

This metadata item includes salaried medical officers who are engaged in administrative duties regardless of the extent of that engagement (for example, clinical superintendent and medical superintendent).

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

If under the relevant award of agreement a full-time employee is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time employee who works 64 hours is 0.8. If a full-time employee under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25.

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

If under the relevant award of agreement a full-time nurse is

paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time nurse who works 64 hours is 0.8. If a full-time nurse under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25.

Comments:

This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Relational attributes

Related metadata references:

Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.88 KB)

Is used in the formation of Establishment (mental health)—full-time equivalent staff (paid), total N[NNN{.N}] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

This data element should be derived from the following:

- Consultant psychiatrists and psychiatrists
- Medical officers who are registered to practise psychiatry under the relevant State or Territory Medical Registration Board; or who are fellows of the Royal Australian and New Zealand College of Psychiatrists or registered with Health Insurance Commission as a specialist in Psychiatry
- Psychiatry registrars and trainees
- Medial officers who are formal trainees within the Royal Australian and New Zealand College of Psychiatrists Postgraduate Training Program
- Other medical officers
- Medical officers employed or engaged by the organisation who are neither registered as psychiatrists within the State or Territory nor formal trainees within the Royal Australian and New Zealand

College of Psychiatrists Postgraduate Training Program.

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Full-time equivalent staff—social workers

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (social workers), average N[NNN{.N}]
METeOR identifier:	287607
Registration status:	Health, Standard 08/12/2004
Definition:	The average number of full-time equivalent staff units paid for all **social workers** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (social workers)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	Persons who have completed a course of recognised training and are eligible for membership of the Australian Association of Social Workers. The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items. Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).
Comments:	This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Information specific to this data set:

For the Mental health establishments national minimum data set reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Full-time equivalent staff—student nurses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (student nurses), average N[NNN{.N}]
METeOR identifier:	270499
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **student nurses** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (student nurses)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. If under the relevant award of agreement a full-time nurse is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time nurse who works 64 hours is 0.8. If a full-time nurse under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25. Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items. Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).
Comments:	This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.88 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008

Full-time equivalent staff—trainee/pupil nurses

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (trainee/pupil nurses), average N[NNN{.N}]
METeOR identifier:	270493
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of full-time equivalent staff units paid for all **trainee/pupil nurses** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (trainee/pupil nurses)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN{.N}]
Maximum character length:	5
Unit of measure:	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

Guide for use:	The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight. If under the relevant award of agreement a full-time nurse is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time nurse who works 64 hours is 0.8. If a full-time nurse under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25. Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items. Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).
Comments:	This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.88 KB)

Implementation in Data Set Specifications:

Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

Implementation start date: 01/07/2008