National Health Data Dictionary Version 13.3 Volume 4 Data elements Li to Po

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Any enquiries about or comments on this publication should be directed to:

National Data Development and Standards Unit
Australian Institute of Health and Welfare
GPO Box 570
Canberra ACT 2601
Email: datadevelopment@aihw.gov.au
Phone: (02) 6244 1222 Fax: (02) 6244 1166

List of metadata items

Data Element Technical Names

Data Elements

Lipid-lowering therapy status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—lipid-lowering therapy status, code NN
METeOR identifier:	285159
Registration status:	Health, Standard 04/06/2004
Definition:	The person's lipid-lowering therapy status, as represented by a code.
Data Element Concept:	Person—lipid-lowering 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 - patient refusal
22	Not given - true allergy to lipid lowering therapy
23	Not given - previous myopathy
24	Not given - hepatic dysfunction
25	Not given - other

Supplementary values:

Value	Meaning
90	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODES 21 - 25 Not given

If recording `Not given', record the principal reason if more than one code applies.

Data element attributes

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Lipid-lowering therapy status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.12 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Standard 07/12/2005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 collected at any time point during the management of the current event (i.e. at the time of triage, at times during the admission, or at the time of discharge).

Listing date for care

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective care waiting list episode—listing date for care, DDMMYYYY
METeOR identifier:	269957
Registration status:	Health, Standard 01/03/2005
Definition:	The date on which a hospital or a community health service accepts notification that a patient/client requires care/treatment.
Data Element Concept:	Elective care waiting list episode—listing date for care

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 elective surgery, the listing date is the date on which the patient is added to an elective surgery waiting list. The acceptance of the notification by the hospital or community health service is conditional upon the provision of adequate information about the patient and the appropriateness of the patient referral.
Comments:	The hospital or community health service should only accept a patient onto the waiting list when sufficient information has been provided to fulfil state/territory, local and national reporting requirements.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Listing date for care, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.5 KB) Is used in the formation of Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] Health, Standard 01/03/2005 Is used in the formation of Elective surgery waiting list episode—waiting time (at a census date), 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

Living arrangement

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—living arrangement, health sector code N
METeOR identifier:	299712
Registration status:	Health, Standard 14/06/2005
Definition:	Whether a person usually resides alone or with others, as represented by a code.
Context:	Client support needs and clinical setting.
Data Element Concept:	Person—living arrangement

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Lives alone
	2	Lives with others
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Collection methods:	This item does not seek to describe the quality of the arrangements but merely the fact of the arrangement. It is recognised that this item may change on a number of occasions during the course of an episode of care.
Comments:	Whether or not a person lives alone is a significant determinant of risk. Living alone may preclude certain treatment approaches (e.g. home dialysis for end-stage renal disease). Social isolation has also been shown to have a negative impact on prognosis in males with known coronary artery disease with several studies suggesting increased mortality rates in those living alone or with no confidant.

Source and reference attributes

Submitting organisation:	Cardiovascular Data Working Group

Relational attributes

Related metadata references:	Supersedes Living arrangement, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.03 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

Location of impairment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—location of impairment of body structure, code (ICF 2001) N
METeOR identifier:	320177
Registration status:	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
Definition:	The location of a person's impairment in a specified body structure, as represented by a code.
Context:	Human functioning and disability
Data Element Concept:	Person—location of impairment of body structure

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	More than one region
1	Right
2	Left
3	Both sides
4	Front
5	Back
6	Proximal
7	Distal

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.

Impairments of body structure are problems in body structure such as a loss or significant departure from population standards or averages.

Use only one code. Select the one that best describes the situation with this structure. Combinations are not possible.

CODE 0 More than one region (except both sides)

Used when the impairment is present in more than one body location (but not bilaterally see code 3); for example when burn scars affect many areas of skin.

CODE 1 Right

Used when the impairment is present to the right of the midline of the person's body.

CODE 2 Left

Used when the impairment is present to the left of the midline of the person's body.

CODE 3 Both sides (bilateral)

Used when the impairment is two-sided and disposed on opposite sides of the midline axis of the body, for example bilateral joint deformities.

CODE 4 Front

Used when the impairment is present in front of a line passing through the midline of the body when viewed from the side.

CODE 5 Back

Used when the impairment is present behind a line passing through the midline of the body when viewed from the side.

CODE 6 Proximal

Used when the impairment is situated towards the point of origin or attachment, as of a limb or bone (opposed to distal), for example the end of the structure that is closer to the centre of the body.

CODE 7 Distal

Used when the impairment is situated away from the point of origin or attachment, as of a limb or bone (opposed to proximal), for example the end of structure that is further away from the centre of the body.

CODE 8 Not specified

Used when there is an impairment of body structure but the location of the impairment is not recorded.

CODE 9 Not applicable

Used when it is not appropriate to code the location of an impairment of body structure.

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 is to be used in conjunction with specified body structures, for example, 'impairment of proximal structures related to movement'. This data element may also be used in conjunction with Person—extent of impairment of body structure, code (ICF 2001) N and Person—nature of impairment of body structure, code (ICF 2001).

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:	Body structures cluster Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Lot/section number (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—lot/section identifier, N[X(14)]
METeOR identifier:	270031
Registration status:	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
Definition:	The unique identifier for the lot/section of the location where a person resides.
Data Element Concept:	Person (address)—lot/section identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	N[X(14)]
Maximum character length:	15

Data element attributes

Collection and usage attributes

Guide for use:	This standard is suitable for postal purposes as well as the physical identification of addresses. A lot number shall be used only when a street number has not been specifically allocated or is not readily identifiable with the property. For identification purposes, the word 'Lot' or 'Section' should precede the lot number and be separated by a space. Examples are as follows: Section 123456 Lot 716 Lot 534A Lot 17 Jones Street
Collection methods:	The lot/section number is positioned before the Street name and type, located in the same line containing the Street name.
Comments:	Lot/section numbers are generally used only until an area has been developed.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	AS 4590 Interchange of client information, Australia Post Address Presentation Standard

Relational attributes

Related metadata references:	Supersedes Lot/section number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.34 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

Lot/section number (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—lot/section identifier, N[X(14)]
METeOR identifier:	290230
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The unique identifier for the lot/section of the location of an organisation.
Data Element Concept:	Service provider organisation (address)—lot/section identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	N[X(14)]
Maximum character length:	15

Data element attributes

Collection and usage attributes

Guide for use:	This standard is suitable for postal purposes as well as the physical identification of addresses. A lot number shall be used only when a street number has not been specifically allocated or is not readily identifiable with the property. For identification purposes, the word 'Lot' or 'Section' should precede the lot number and be separated by a space. Examples are as follows: Section 123456 Lot 716 Lot 534A Lot 17 Jones Street
Collection methods:	The lot/section number is positioned before the Street name and type, located in the same line containing the Street name.
Comments:	Lot/section numbers are generally used only until an area has been developed.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	AS 4590 Interchange of client information, 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

Lower limb amputation due to vascular disease

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—lower limb amputation due to vascular disease, code N
METeOR identifier:	270162
Registration status:	Health, Standard 01/03/2005
Definition:	Whether a person has undergone an amputation of toe, forefoot or leg (above or below knee), due to vascular disease, as represented by a code.
Data Element Concept:	Person—lower limb amputation due to vascular disease

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Lower limb amputation - occurred in the last 12 months
	2	Lower limb amputation - occurred prior to the last 12 months
	3	Lower limb amputation - occurred both in and prior to the last 12 months
	4	No history of lower limb amputation due to vascular disease
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Collection methods:	Ask the individual if he/she has had an amputated toe or forefoot or leg (above or below knee), not due to trauma or causes other than vascular disease. If so determine when it was undertaken; within or prior to the last 12 months (or both). Alternatively obtain this information from appropriate documentation.

Data element attributes

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.
Reference documents:	Duffy MD, John C and Patout MD, Charles A. 1990. Management of the Insensitive Foot in Diabetes: Lessons from Hansen's Disease. Military Medicine, 155:575-579. Edmonds M, Boulton A, Buckenham T et al. Report of the Diabetic Foot and

Amputation Group. Diabet Med 1996; 13: S27-42. Sharon R O'Rourke and Stephen Colagiuri: The Lower Limb in People With Diabetes; Content 1997/98 Australian Diabetes Society. Colagiuri S, Colagiuri R, Ward J. National Diabetes Strategy and Implementation Plan. Canberra: Diabetes Australia, 1998.

Relational attributes

Related metadata references:

Supersedes Lower limb amputation due to vascular disease, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.61 KB)

Implementation in Data Set Specifications:

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

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

Information specific to this data set:

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 (The Lower Limb in People With Diabetes; 1997/98 Australian Diabetes Society).

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 in population aged over 75 years. As stated by Duffy and authors the rate of lower extremity amputations can be reduced by 50% by the institution of monofilament testing in a preventive care program.

Main language other than English spoken at home

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—main language other than English spoken at home, code (ASCL 2005) NN{NN}
METeOR identifier:	304133
Registration status:	Health, Standard 08/02/2006 Community services, Standard 29/04/2006 Housing assistance, Standard 10/02/2006
Definition:	The language reported by a person as the main language other than English spoken by that person in his/her home (or most recent private residential setting occupied by the person) to communicate with other residents of the home or setting and regular visitors, as represented by a code.
Data Element Concept:	Person—main language other than English spoken at home

Value domain attributes

Representational attributes

Classification scheme:	Australian Standard Classification of Languages 2005
Representation class:	Code
Data type:	Number
Format:	NN{NN}
Maximum character length:	4

Collection and usage attributes

Guide for use:

The Australian Standard Classification of Languages (ASCL) has a three- level hierarchical structure. The most detailed level of the classification consists of base units (languages) which are represented by four-digit codes. The second level of the classification comprises narrow groups of languages (the Narrow Group level), identified by the first two digits. The most general level of the classification consists of broad groups of languages (the Broad Group level) and is identified by the first digit. The classification includes Australian Indigenous languages and sign languages.

For example, the Lithuanian language has a code of 3102. In this case 3 denotes that it is an Eastern European language, while 31 denotes that it is a Baltic language. The Pintupi Aboriginal language is coded as 8713. In this case 8 denotes that it is an Australian Indigenous language and 87 denotes that the language is Western Desert language.

Language data may be output at the Broad Group level, Narrow Group level or base level of the classification. If necessary significant Languages within a Narrow Group can be presented separately while the remaining Languages in the Narrow Group are aggregated. The same principle can be adopted to highlight significant Narrow Groups within a Broad Group.

Data element attributes

Collection and usage attributes

Collection methods:

Recommended question:

Do you/Does the person/Does (name) speak a language other than English at home? (If more than one language, indicate the one that is spoken most often.)

No (English only) ____

Yes, Italian ____

Yes, Greek ____

Yes, Cantonese ____

Yes, Mandarin ____

Yes, Arabic ____

Yes, Vietnamese ____

Yes, German ____

Yes, Spanish

Yes, Tagalog (Filipino) ____

Yes, Other (please specify) _____

This list reflects the nine most common languages other than English spoken in Australia.

Languages may be added or deleted from the above short list to reflect characteristics of the population of interest.

Alternatively a tick box for 'English' and an 'Other - please specify' response category could be used.

Comments:

This metadata item is consistent with that used in the Australian Census of Population and Housing and is recommended for use whenever there is a requirement for comparison with Census data.

This data element is important in identifying those people most likely to suffer disadvantage in terms of their ability to access services due to language and/or cultural difficulties. In conjunction with Indigenous status, Proficiency in spoken English and Country of birth this data element forms the minimum core set of cultural and language indicators recommended by the Australian Bureau of Statistics (ABS).

Data on main language other than English spoken at home are regarded as an indicator of 'active' ethnicity and also as useful for the study of inter-generational language retention. The availability of such data may help providers of health and community services to effectively target the geographic areas or population groups that need those services. It may be used for the investigation and development of language services such as interpreter/ translation services.

Source and reference attributes

Origin:

Health Data Standards Committee

National Community Services Data Committee

Australian Bureau of Statistics 2005. Australian Standard Classification of Languages (ASCL) 2005. Cat. no. 1267.0. 2nd Edition, Canberra: ABS. Viewed 29 July 2005.

Relational attributes

Related metadata references:

See also Person—preferred language, code (ASCL 2005) NN{NN} Health, Standard 08/02/2006, Community services, Standard 29/04/2006

Supersedes Person—main language other than English spoken at home, code (ASCL 1997) NN{NN} Health, Superseded 08/02/2006, Community services, Superseded 29/04/2006, Housing assistance, Not progressed 13/10/2005

Main occupation of person

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—occupation (main), code (ANZSCO 1st edition) N[NNN]{NN}
METeOR identifier:	350899
Registration status:	Health, Standard 04/07/2007 Community services, Standard 27/03/2007 Housing assistance, Standard 10/08/2007
Definition:	The job in which the person is principally engaged, as represented by a code.
Data Element Concept:	Person—occupation (main)

Value domain attributes

Representational attributes

Classification scheme:	Australian and New Zealand Standard Classification of Occupations, First edition, 2006
Representation class:	Code
Data type:	Number
Format:	N[NNN]{NN}
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:	A job in any given establishment is a set of tasks designed to be performed by one individual in return for a wage or salary. For persons with more than one job, the main job is the one in which the person works the most hours. Caution is advised in its use with regard to service providers as their activity as a service provider may not be their main occupation.
Collection methods:	This metadata item should only be collected from people whose Labour force status is employed. Occupation is too complex and diverse an issue to fit neatly into any useable small group of categories. Therefore ABS recommend that this metadata item be collected by using the following two open-ended questions: Q1. In the main job held last week (or other recent reference period), what was your/the person's occupation? Q2. What are the main tasks that you/the person usually perform(s) in that occupation? The information gained from these two questions can then be used to select an appropriate code from the ANZSCO at any of the available levels (see Guide for use section). If only one question is asked, question one should be used. The use of question one only, however, sometimes elicits responses which do not provide a clear occupation title and specification

of tasks performed. As a result accurate coding at unit group or occupation level may not be possible.

While agencies are encouraged to use the recommended question described above, it is acknowledged that this is not always possible in practice. For example, where the data collection is a by-product of the provision of a health or community service, the information may be ascertained using different means. However, due to the complexities of the metadata item 'Main occupation of person', this will result in inaccurate information. The recommended question should be used wherever possible.

Comments:

This metadata item may be useful in gaining an understanding of a clients situation and needs. For example, the occupation of a person with a disability may be directly relevant to the type of aids that they require.

National Health Data Dictionary (NHDD) specific:

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

Source and reference attributes

Origin:

Australian Bureau of Statistics 2006. Australian New Zealand Standard Classification of Occupations (ANZSCO) (Cat. no. 1220.0) (First edition), Viewed 13 March 2007.

Relational attributes

Related metadata references:

Supersedes Person—occupation (main), code (ASCO 2nd edn) N[NNN]{-NN} Health, Superseded 04/07/2007, Community services, Superseded 27/03/2007, Housing assistance, Superseded 10/08/2007

See also Person—labour force status, code N Health, Standard 01/03/2005, Community services, Standard 01/03/2005, Housing assistance, Standard 01/03/2005

Main treatment type 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 type (main), code N
METeOR identifier:	270056
Registration status:	Health, Standard 01/03/2005
Definition:	The main activity determined at assessment by the treatment provider to treat the client's alcohol and/or drug problem for the principal drug of concern, as represented by a code.
Data Element Concept:	Episode of treatment for alcohol and other drugs—treatment type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Withdrawal management (detoxification)
2	Counselling
3	Rehabilitation
4	Pharmacotherapy
5	Support and case management only
6	Information and education only
7	Assessment only
8	Other

Collection and usage attributes

Guide for use:

CODE 1 Withdrawal management (detoxification)

This code refers to any form of withdrawal management, including medicated and non-medicated, in any delivery setting.

CODE 2 Counselling

This code refers to any method of individual or group counselling directed towards identified problems with alcohol and/or other drug use or dependency. This code excludes counselling activity that is part of a rehabilitation program as defined in Code 3.

CODE 3 Rehabilitation

This code refers to an intensive treatment program that integrates a range of services and therapeutic activities that may include counselling, behavioural treatment approaches, recreational activities, social and community living skills, group work and relapse prevention. Rehabilitation treatment can provide a high level of support (i.e. up to 24 hours a day) and

tends towards a medium to longer-term duration. Rehabilitation activities can occur in residential or non-residential settings. Counselling that is included within an overall rehabilitation program should be coded to Code 3 for Rehabilitation, not to Code 2 as a separate treatment episode for counselling.

CODE 4 Pharmacotherapy

Refers to pharmacotherapies that include those used as maintenance therapies (e.g. naltrexone, buprenorphine, and methadone treatment) and those used as relapse prevention. Use Code 1 (withdrawal management) where a pharmacotherapy is used solely for withdrawal. Note collection exclusions: excludes treatment episodes for clients who are on an opioid pharmacotherapy maintenance program and are not receiving any other form of treatment.

CODE 5 Support and case management only

Refers to when there is no treatment provided to the client other than support and case management (e.g. treatment provided through youth alcohol and drug outreach services). This choice only applies where support and case management treatment is recorded as individual client data and the treatment activity is not included in any other category.

CODE 6 Information and education only

Refers to when there is no treatment provided to the client other than information and education. It is noted that, in general, service contacts would include a component of information and education.

CODE 7 Assessment only

Refers to when there is no treatment provided to the client other than assessment. It is noted that, in general, service contacts would include an assessment component.

Data element attributes

Collection and usage attributes

Guide for use:

Only one code to be selected.

To be completed at assessment or commencement of treatment.

The main treatment type is the principal activity as judged by the treatment provider that is necessary for the completion of the treatment plan for the principal drug of concern. The main treatment type for alcohol and other drugs is the principal focus of a single treatment episode. Consequently, each treatment episode will only have one main treatment type.

For brief interventions, the main treatment type may apply to as few as one contact between the client and agency staff.

Comments:

Information about treatment provided is of fundamental importance to service delivery and planning.

Source and reference attributes

Submitting organisation:

Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references:

Supersedes Main treatment type for alcohol and other drugs, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.87 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

Major diagnostic category

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN
METeOR identifier:	270400
Registration status:	Health, Standard 01/03/2005
Definition:	The category into which the patient's diagnosis and the associated Australian refined diagnosis related group (ARDG) falls, as represented by a code.
Data Element Concept:	Episode of admitted patient care—major diagnostic category

Value domain attributes

Representational attributes

Classification scheme:	Australian Refined Diagnosis Related Groups version 5.1
Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Data element attributes

Collection and usage attributes

Guide for use:	Version effective 1 July each year
Comments:	This metadata item has been created to reflect the development of Australian refined diagnosis related groups (AR-DRGs) (as defined in the metadata item Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA) by the Acute and Co-ordinated Care Branch, Commonwealth Department of Health and Ageing. Due to the modifications in the diagnosis related group logic for the AR-DRGs, it is necessary to generate the major diagnostic category to accompany each diagnosis related group. The construction of the pre-major diagnostic category logic means diagnosis related groups are no longer unique. Certain pre-major diagnostic category diagnosis related groups may occur in more than one of the 23 major diagnostic categories.

Source and reference attributes

Submitting organisation:	Department of Health and Ageing, Acute and Co-ordinated Care Branch

Relational attributes

Related metadata references:	Is formed using Episode of care—principal diagnosis, code (ICD-10-AM 5th edn) ANN{.N[N]} Health, Superseded 05/02/2008 Is formed using Episode of care—additional diagnosis, code

(ICD-10-AM 5th edn) ANN{.N[N]} Health, Superseded 05/02/2008

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 admitted patient care—admission date, DDMMYYYY Health, Standard 01/03/2005

Supersedes Major diagnostic category, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.59 KB)

See also Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA 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

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

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

Is formed using Person—weight (measured), total grams NNNN 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 Episode of care—mental health legal status, code N 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

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

Marital status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—marital status, code N
METeOR identifier:	291045
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 10/02/2006
Definition:	A person's current relationship status in terms of a couple relationship or, for those not in a couple relationship, the existence of a current or previous registered marriage, as represented by a code.
Data Element Concept:	Person—marital status

Value domain attributes

Representational attributes

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

Permissible values: / *Supplementary values:*

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

Collection and usage attributes

Guide for use:

Refers to the current marital status of a person.

CODE 2 Widowed

This code usually refers to registered marriages but when self reported may also refer to de facto marriages.

CODE 4 Separated

This code refers to registered marriages but when self reported may also refer to de facto marriages.

CODE 5 Married (registered and de facto)

Includes people who have been divorced or widowed but have since re-married, and should be generally accepted as applicable to all de facto couples, including of the same sex.

CODE 6 Not stated/inadequately described

This code is not for use on primary collection forms. It is primarily for use in administrative collections when transferring data from data sets where the item has not been collected.

Source and reference attributes

Origin: The ABS standards for the collection of Social and Registered marital status appear on the ABS Website. Australian Bureau of Statistics. Family, household and income unit variables. Cat. no. 1286.0. Canberra: ABS.

Data element attributes

Collection and usage attributes

Collection methods: This metadata item collects information on social marital status. The recommended question module is:

Do you/Does the person usually live with a partner in a registered or de facto marriage?

Yes, in a registered marriage

Yes, in a defacto marriage

No, never married

No, separated

No, divorced

No, widowed

It should be noted that information on marital status is collected differently by the ABS, using a set of questions. However, the question outlined above is suitable and mostly sufficient for use within the health and community services fields. See Source document for information on how to access the ABS standards.

While agencies are encouraged to use the recommended question described above, it is acknowledged that this is not always possible in practice. For example, where the data collection is a by-product of the provision of a health or community service, the information may be ascertained using different means. However, the recommended question should be used wherever practically possible.

Comments: The ABS standards identify two concepts of marital status:

- Registered marital status - defined as whether a person has, or has had, a registered marriage;
- Social marital status - based on a person's living arrangement (including de facto marriages), as reported by the person.

It is recommended that the social marital status concept be collected when information on social support/home arrangements is sought, whereas the registered marital status concept need only be collected where it is specifically required for the purposes of the collection.

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

Source and reference attributes

Origin: National Health Data Standards Committee

National Community Services Data Committee

Relational attributes

Related metadata references:

Supersedes Person—marital status, code N Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005

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

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

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

Information specific to this data set:

For data collection using Computer Assisted Telephone Interviewing (CATI) the recommended question is:

Which of the following best describes your current marital status?

(Read options. Single response. Interviewer note: 'De facto' equals 'Living with partner')

Married

Living with partner

Widowed

Divorced

Separated

Never married

Not stated/inadequately described (this category is not read out by interviewer)

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

Maternal medical conditions

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female (pregnant)—maternal medical condition, code (ICD-10-AM 6th edn) ANN{.N[N]}
METeOR identifier:	361073
Registration status:	Health, Standard 05/02/2008
Definition:	Pre-existing maternal diseases and conditions, and other diseases, illnesses or conditions arising during the current pregnancy, that are not directly attributable to pregnancy but may significantly affect care during the current pregnancy and/or pregnancy outcome, as represented by a code.
Context:	Perinatal statistics
Data Element Concept:	Female (pregnant)—maternal medical condition

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:	Examples of such conditions include essential hypertension, psychiatric disorders, diabetes mellitus, epilepsy, cardiac disease and chronic renal disease. There is no arbitrary limit on the number of conditions specified.
Comments:	Maternal medical conditions may influence the course and outcome of the pregnancy and may result in antenatal admission to hospital and/or treatment that could have adverse effects on the fetus and perinatal morbidity.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Female (pregnant)—maternal medical condition, code (ICD-10-AM 5th edn) ANN{.N[N]} Health, Superseded 05/02/2008

Medicare card number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—government funding identifier, Medicare card number N(11)
METeOR identifier:	270101
Registration status:	Health, Standard 01/03/2005 Community services, Recorded 27/03/2007
Definition:	Person identifier, allocated by the Health Insurance Commission to eligible persons under the Medicare scheme, that appears on a Medicare card.
Context:	Medicare utilisation statistics. Persons eligible for Medicare services.
Data Element Concept:	Person—government funding identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	Number
Format:	N(11)
Maximum character length:	11

Collection and usage attributes

Guide for use:	Full Medicare number for an individual (i.e. family number plus person (individual reference) number).
Comments:	The Medicare card number is printed on a Medicare card and is used to access Medicare records for an eligible person. Up to 9 persons can be included under the one Medicare card number with up to five persons appearing on one physical card. Persons grouped under one Medicare card number are often a family, however, there is no requirement for persons under the same Medicare card number to be related. A person may be shown under separate Medicare card numbers where, for example, a child needs to be included on separate Medicare cards held by their parents. As a person can be identified on more than one Medicare card this is not a unique identifier for a person.

Data element attributes

Collection and usage attributes

Guide for use:	The Medicare card number should only be collected from persons eligible to receive health services that are to be funded by the Commonwealth government. The number should be reported to the appropriate government agency to reconcile payment for the service provided. The data should not be used by private sector organisations for any other purpose unless specifically authorised by law. For example, data linkage

should not be carried out unless specifically authorised by law.

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

Source and reference attributes

Submitting organisation: Standards Australia

Origin: AS5017 Health care client identification

Relational attributes

Related metadata references: Supersedes Medicare card number, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.62 KB)

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 Health, Superseded 04/05/2005

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

Medicare eligibility status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—eligibility status, Medicare code N
METeOR identifier:	351922
Registration status:	Health, Standard 04/07/2007
Definition:	An indicator of a person's eligibility for Medicare at the time of the episode of care, as specified under the Commonwealth Health Insurance Act 1973, as represented by a code.
Context:	Admitted patient care: To facilitate analyses of hospital utilisation and policy relating to health care financing.
Data Element Concept:	Person—eligibility status

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Eligible
	2	Not eligible
Supplementary values:	9	Not stated/unknown

Data element attributes

Collection and usage attributes

Guide for use:

Eligible persons are

- Permanent residents of Australia
- Persons who have an application for permanent residence (not an aged parent visa), and have either:

- a spouse, parent or child who is an Australian citizen or permanent resident, OR

- authority from Department of Immigration and Multicultural and Indigenous Affairs to work

- Foreign spouses of Australian residents:

- must have an application for permanent residence, as above

- Asylum seekers who have been issued with valid temporary visas. The list of visas is subject to changes which may be applied by the Department of Immigration and Multicultural Affairs.
- American Fulbright scholars studying in Australia (but not their dependents)
- Diplomats and their dependants from reciprocal health countries (excluding New Zealand and Norway) have full

access to Medicare without the restrictions for American Fulbright scholars.

Reciprocal health care agreements

Residents of countries with whom Australia has Reciprocal health care agreements are also eligible under certain circumstances. Australia has Reciprocal Health Care Agreements with Ireland, Italy, Finland, Malta, the Netherlands, New Zealand, Norway, Sweden and the United Kingdom. These Agreements give visitors from these countries access to Medicare and the Pharmaceutical Benefits Scheme for the treatment of an illness or injury which occurs during their stay, and which requires treatment before returning home (that is, these Agreements cover immediately necessary medical treatment, elective treatment is not covered). The Agreements provide for free accommodation and treatment as public hospital services, but do not cover treatment as a private patient in any kind of hospital.

– The Agreements with Finland, Italy, Malta, the Netherlands, Norway, Sweden and the United Kingdom provide free care as a public patient in public hospitals, subsidised out-of-hospital medical treatment under Medicare, and subsidised medicines under the Pharmaceutical Benefits Scheme.

– The Agreements with New Zealand and Ireland provide free care as a public patient in public hospitals and subsidised medicines under the Pharmaceutical Benefits Scheme, but do not cover out-of-hospital medical treatment.

– Visitors from Italy and Malta are covered for a period of six months from the date of arrival in Australia only.

Eligible patients may elect to be treated as either a public or a private patient.

A newborn will usually take the Medicare eligibility status of the mother. However, the eligibility status of the father will be applied to the newborn if the baby is not eligible solely by virtue of the eligibility status of the mother.

For example, if the mother of a newborn is an ineligible person but the father is eligible for Medicare, then the newborn will be eligible for Medicare.

Not eligible/ineligible: means any person who is not Medicare eligible. Ineligible patients may not elect to be treated as a public patient.

Prisoners are ineligible for Medicare, under Section 19 (2) of the Health Insurance Act 1973.

Relational attributes

Related metadata references:

Supersedes Person—eligibility status, Medicare code N Health, Superseded 04/07/2007

Mental health legal status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—mental health legal status, code N
METeOR identifier:	270351
Registration status:	Health, Standard 01/03/2005
Definition:	Whether a person is treated on an involuntary basis under the relevant state or territory mental health legislation, at any time during an episode of admitted patient care, an episode of residential care or treatment of a patient/client by a community based service during a reporting period, as represented by a code.
Data Element Concept:	Episode of care—mental health legal status

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Involuntary patient
2	Voluntary patient

Supplementary values:

3	Not permitted to be reported under legislative arrangements in the jurisdiction

Collection and usage attributes

Guide for use:

CODE 1 Involuntary patient

Involuntary patient should only be used by facilities which are approved for this purpose. While each state and territory mental health legislation differs in the number of categories of involuntary patient that are recognised, and the specific titles and legal conditions applying to each type, the legal status categories which provide for compulsory detention or compulsory treatment of the patient can be readily differentiated within each jurisdiction. These include special categories for forensic patients who are charged with or convicted of some form of criminal activity. Each state/territory health authority should identify which sections of their mental health legislation provide for detention or compulsory treatment of the patient and code these as involuntary status.

CODE 2 Voluntary patient

Voluntary patient to be used for reporting to the NMDS-Community mental health care, where applicable.

CODE 3 Not permitted to be reported under legislative arrangements in the jurisdiction

Not permitted to be reported under legislative arrangements in the jurisdiction, is to be used for reporting to the National

Minimum Data Set - Community mental health care, where applicable.

Data element attributes

Collection and usage attributes

Guide for use:

The mental health legal status of admitted patients treated within approved hospitals may change many times throughout the episode of care.

Patients may be admitted to hospital on an involuntary basis and subsequently be changed to voluntary status; some patients are admitted as voluntary but are transferred to involuntary status during the hospital stay. Multiple changes between voluntary and involuntary status during an episode of care in hospital or treatment in the community may occur depending on the patient's clinical condition and his/her capacity to consent to treatment.

Similarly, the mental health legal status of residents treated within residential care services may change on multiple occasions throughout the episode of residential care or residential stay.

Collection methods:

Admitted patients to be reported as involuntary if the patient is involuntary at any time during the episode of care.

Residents in **residential mental health services** to be reported as involuntary if the resident is involuntary at any time during the episode of residential care.

Patients of ambulatory mental health care services to be reported as involuntary if the patient is involuntary at the time of a service contact.

Source and reference attributes

Origin:

National Health Data Committee

Relational attributes

Related metadata references:

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 – diagnosis related group, code (AR-DRG v5.1) ANNA 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

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

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

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

Mental health service contact date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Mental health service contact—service contact date, DDMMYYYY
METeOR identifier:	295481
Registration status:	Health, Standard 08/12/2004
Definition:	The date of each mental health service contact between a health service provider and patient/client.
Data Element Concept:	Mental health service contact—service 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

Collection methods:	Requires services to record the date of each service contact, including the same date where multiple visits are made on one day (except where the visits may be regarded as a continuation of the one service contact). Where an individual patient/client participates in a group activity, a service contact date is recorded if the person's participation in the group activity results in a dated entry being made in the patient's/client's record. For collection from community based (ambulatory and non-residential) agencies.
Comments:	The service contact is required for clinical audit and other quality assurance purposes.

Relational attributes

Implementation in Data Set Specifications:	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:

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

The National Health Data Committee acknowledges that information about group sessions or activities that do not result in a dated entry being made in each individual participant's patient/client record is not obtained from the data collected from this metadata item.

Mental health service contact duration

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Mental health service contact—service contact duration, total minutes NNN
METeOR identifier:	286682
Registration status:	Health, Standard 08/12/2004
Definition:	The time from the start to finish of a service contact.
Data Element Concept:	Mental health service contact—mental health service contact duration

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	For group sessions the time for the patient/client in the session is recorded for each patient/client, regardless of the number of patients/clients or third parties participating or the number of service providers providing the service. Writing up details of service contacts is not to be reported as part of the duration, except if during or contiguous with the period of patient/client or third party participation. Travel to or from the location at which the service is provided, for example to or from outreach facilities or private homes, is not to be reported as part of the duration of the service contact.
Comments:	Counting the duration for each patient/client in a group session means that this data element cannot be used to measure the duration of service contacts from the perspective of the service provider.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:	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

Mental health service contact—patient/client participation indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Mental health service contact—patient/client participation indicator, yes/no code N
METeOR identifier:	286859
Registration status:	Health, Standard 08/12/2004
Definition:	Whether the patient/client has participated in a service contact, as represented by a code.
Data Element Concept:	Mental health service contact—patient/client participation 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:

Service contacts are not restricted to in-person communication but can include telephone, video link or other forms of direct communication.

- Code 1 is to be used for service contacts between a specialised mental health service provider and the patient/client in whose clinical record the service contact would normally warrant a dated entry, where the patient/client is participating.
- Code 2 is to be used for service contacts between a specialised mental health service provider and a third party(ies) where the patient/client, in whose clinical record the service contact would normally warrant a dated entry, is not participating.

Relational attributes

Implementation in Data Set Specifications:

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

Mental health service contact—session type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Mental health service contact—session type, code N
METeOR identifier:	286832
Registration status:	Health, Standard 08/12/2004
Definition:	Whether a service contact is provided for one or more patient(s)/client(s), as represented by a code.
Data Element Concept:	Mental health service contact—session type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Individual session
2	Group session

Data element attributes

Collection and usage attributes

Guide for use:

A service contact is regarded as an individual session where the service is provided for one patient/client with or without third party involvement.

A service contact is regarded as a group session where two or more patients/clients are participating in the service contact with or without third parties and the nature of the service would normally warrant dated entries in the clinical records of the patients/clients in question.

A service contact is also regarded as a group session where third parties for two or more patients/clients are participating in the service contact without the respective patients/clients and the nature of the service would normally warrant dated entries in the clinical records of the patients/clients in question.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

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

Mental health services grants to non-government organisations by non-health departments

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	State or Territory Government—mental health services grants to non-government organisations by non-health departments, total Australian currency N[N(8)]
METeOR identifier:	298940
Registration status:	Health, Standard 07/12/2005
Definition:	Total amount of money in the form of grants made by state or territory departments outside the health portfolios directly to non-government organisations specifically for the provision of mental health activities or programs (other than staffed residential services).
Data Element Concept:	State or Territory Government—mental health services grants to non-government organisations by non-health departments

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Where the exact dollar amount is unable to be provided an estimate should be derived from information available to the state or territory health department.

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:

Do not include grants made by the state or territory health departments.

Do not include grants to non-government organisations for provision of staffed residential services.

Activities or programs for which the grant has been provided must have a primary function of providing treatment, rehabilitation or community health and related support and information services for people with a mental disorder or psychiatric disability, their carers or the broader community. These include accommodation, advocacy, community awareness, health promotion, counselling, independent living skills, psychosocial, recreation, residential, respite and self-help services. Mental health-related research is excluded. These may include, for example, a coordinated approach to service provision for people with a mental disorder or psychiatric disability for which most funding is provided by the state or territory health department, but some funding provided by other agencies, such as housing.

Grants are only to be reported at the state or territory level and should not be reported at any other level.

Method of birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—birth method, code N
METeOR identifier:	295349
Registration status:	Health, Standard 06/09/2006
Definition:	The method of complete expulsion or extraction from its mother of a product of conception in a birth event, as represented by a code.
Data Element Concept:	Birth event—birth method

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Vaginal - non-instrumental
	2	Vaginal - forceps
	4	Caesarean section
	5	Vaginal - vacuum extraction
Supplementary values:	9	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Data element attributes

Collection and usage attributes

Guide for use:	In a vaginal breech with forceps to the after coming head, code as vaginal - forceps. In a vaginal breech that has been manually rotated, code as vaginal - non-instrumental. Where forceps/vacuum extraction are used to assist the extraction of the baby at caesarean section, code as caesarean section. Where a hysterotomy is performed to extract the baby, code as caesarean section.
Collection methods:	In the case of multiple births, method of birth should be recorded for each baby born.
Comments:	Note: Code 3, which had a meaning in previous versions of the data standard is no longer used. As is good practice, the code will not be reused.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Birth event—delivery method, code N Health, Superseded 06/09/2006

Implementation in Data Set Specifications: 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

Method of use for principal drug of concern

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Client—method of drug use (principal drug of concern), code N
METeOR identifier:	270111
Registration status:	Health, Standard 01/03/2005
Definition:	The client's self-reported usual method of administering the principal drug of concern, as represented by a code.
Data Element Concept:	Client—method of drug use (principal drug of concern)

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Ingests
2	Smokes
3	Injects
4	Sniffs (powder)
5	Inhales (vapour)
6	Other

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Refers to eating or drinking as the method of administering the principal drug of concern.
Collection methods:	Collect only for principal drug of concern. To be collected on commencement of treatment with a service.
Comments:	Identification of drug use methods is important for minimising specific harms associated with drug use, and is consequently of value for informing treatment approaches.

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Method of use for principal drug of concern, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.73 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

Microalbumin level—albumin/creatinine ratio (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—microalbumin level (measured), albumin/creatinine ratio N[NN].N
METeOR identifier:	270339
Registration status:	Health, Standard 01/03/2005
Definition:	A person's microalbumin level, measured as an albumin/creatinine ratio.
Data Element Concept:	Person—microalbumin level

Value domain attributes

Representational attributes

Representation class:	Ratio
Data type:	Number
Format:	N[NN].N
Maximum character length:	4

Supplementary values:

Value	Meaning
999.9	Not stated/inadequately described

Unit of measure:	Milligram per millimole (mg/mmol)
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Collection methods:

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

Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.

As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate, and if the albumin/creatinine ratio is found to be greater than 3.5 mg/mmol then a timed overnight sample should be obtained for estimation of the albumin excretion rate.

Test for albuminuria by measuring microalbumin in timed or first morning urine sample.

The results considered elevated are

- spot urine 30 to 300 mg/L; or
- timed urine (24 hour collection) 20 to 200 µg/min.

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:

See also Laboratory standard—upper limit of normal range for microalbumin, albumin/creatinine ratio N[NN].N Health, Standard 01/03/2005

Supersedes Microalbumin/protein - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.53 KB)

Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.27 KB)

Implementation in Data Set Specifications:

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

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

Information specific to this data set:

A small amount of protein (albumin) in the urine (microalbuminuria) is an early sign of kidney damage. Microalbuminuria is a strong predictor of macrovascular disease and diabetic nephropathy. Incipient diabetic nephropathy can be detected by urine testing for microalbumin. Incipient diabetic nephropathy is suspected when microalbuminuria is detected in two of three samples collected over a six-month period in patients in whom other causes of an increased urinary album excretion have been excluded.

Diagnosis of microalbuminuria is established if 2 of the 3 measurements are abnormal.

According to the Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus a test for microalbuminuria is to be performed:

- at diagnosis and then every 12 months for patients with Type 2 diabetes,
- 5 years post diagnosis and then every 12 months for patients with Type 1 diabetes,
- if microalbuminuria is present, perform up to two additional measurements in the next 6 weeks.

Microalbumin level—micrograms per minute (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—microalbumin level (measured), total micrograms per minute N[NNN].N
METeOR identifier:	270336
Registration status:	Health, Standard 01/03/2005
Definition:	A person's microalbumin level measured in microgram per minute (µg/min).
Data Element Concept:	Person—microalbumin level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN].N
Maximum character length:	5

Supplementary values:

Value	Meaning
9999.9	Not stated/inadequately described

Unit of measure:	Microgram per minute (µg/min)
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Collection methods:

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

Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.

As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate.

Test for albuminuria by measuring microalbumin in timed or first morning urine sample.

The results considered elevated are

- spot urine 30 to 300mg/L; or
- timed urine (24 hr collection) 20 to 200 µg/min.

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 Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.27 KB)

Supersedes Microalbumin/protein - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.53 KB)

See also Laboratory standard—upper limit of normal range for microalbumin, total micrograms per minute N[NN].N Health, Standard 01/03/2005

Implementation in Data Set Specifications:

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

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

Information specific to this data set:

A small amount of protein (albumin) in the urine (microalbuminuria) is an early sign of kidney damage. Microalbuminuria is a strong predictor of macrovascular disease and diabetic nephropathy. Incipient diabetic nephropathy can be detected by urine testing for microalbumin. Incipient diabetic nephropathy is suspected when microalbuminuria is detected in two of three samples collected over a six-month period in patients in whom other causes of an increased urinary album excretion have been excluded.

Diagnosis of microalbuminuria is established if 2 of the 3 measurements are abnormal.

According to the Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus a test for microalbuminuria is to be performed:

- at diagnosis and then every 12 months for patients with Type 2 diabetes,
- 5 years post diagnosis and then every 12 months for patients with Type 1 diabetes,
- if microalbuminuria is present, perform up to two additional measurements in the next 6 weeks.

Microalbumin level—milligrams per 24 hour (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—microalbumin level (measured), total milligrams per 24 hour N[NNN].N
METeOR identifier:	270337
Registration status:	Health, Standard 01/03/2005
Definition:	A person's microalbumin level measured in milligrams per 24 hours.
Data Element Concept:	Person—microalbumin level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN].N
Maximum character length:	5

Supplementary values:

Value	Meaning
9999.9	Not stated/inadequately described

Unit of measure:	Milligram per 24-hour period (mg/24h)
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Collection methods:

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

Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.

As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate.

Test for albuminuria by measuring microalbumin in timed or first morning urine sample.

The results considered elevated are

- spot urine 30 to 300mg/L; or
- timed urine (24 hr collection) 20 to 200 ug/min.

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 Microalbumin/protein - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.53 KB)

Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.27 KB)

See also Laboratory standard—upper limit of normal range for microalbumin, total milligrams per 24 hour N[NN].N Health, Standard 01/03/2005

Implementation in Data Set Specifications:

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

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

Information specific to this data set:

A small amount of protein (albumin) in the urine (microalbuminuria) is an early sign of kidney damage. Microalbuminuria is a strong predictor of macrovascular disease and diabetic nephropathy. Incipient diabetic nephropathy can be detected by urine testing for microalbumin. Incipient diabetic nephropathy is suspected when microalbuminuria is detected in two of three samples collected over a six-month period in patients in whom other causes of an increased urinary album excretion have been excluded.

Diagnosis of microalbuminuria is established if 2 of the 3 measurements are abnormal.

According to the Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus a test for microalbuminuria is to be performed:

- at diagnosis and then every 12 months for patients with Type 2 diabetes,
- 5 years post diagnosis and then every 12 months for patients with Type 1 diabetes,
- if microalbuminuria is present, perform up to two additional measurements in the next 6 weeks.

Microalbumin level—milligrams per litre (measured)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—microalbumin level (measured), total milligrams per litre N[NNN].N
METeOR identifier:	270335
Registration status:	Health, Standard 01/03/2005
Definition:	A person's microalbumin level measured in milligrams per litre (mg/L).
Data Element Concept:	Person—microalbumin level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN].N
Maximum character length:	5

Supplementary values:

Value	Meaning
9999.9	Not stated/inadequately described

Unit of measure:	Milligram per litre (mg/L)
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Collection methods:

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

Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.

As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate.

Test for albuminuria by measuring microalbumin in timed or first morning urine sample.

The results considered elevated are:

- spot urine 30 to 300mg/L; or
- timed urine (24 hr collection) 20 to 200 ug/min.

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 Microalbumin/protein - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.53 KB)

Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.27 KB)

See also Laboratory standard—upper limit of normal range for microalbumin, total milligrams per litre N[NN].N Health, Standard 01/03/2005

Implementation in Data Set Specifications:

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

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

Information specific to this data set:

A small amount of protein (albumin) in the urine (microalbuminuria) is an early sign of kidney damage. Microalbuminuria is a strong predictor of macrovascular disease and diabetic nephropathy. Incipient diabetic nephropathy can be detected by urine testing for microalbumin. Incipient diabetic nephropathy is suspected when microalbuminuria is detected in two of three samples collected over a six-month period in patients in whom other causes of an increased urinary album excretion have been excluded.

Diagnosis of microalbuminuria is established if 2 of the 3 measurements are abnormal.

According to the Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus a test for microalbuminuria is to be performed:

- at diagnosis and then every 12 months for patients with Type 2 diabetes,
- 5 years post diagnosis and then every 12 months for patients with Type 1 diabetes,
- if microalbuminuria is present, perform up to two additional measurements in the next 6 weeks.

Microalbumin level—upper limit of normal range (albumin/creatinine ratio)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for microalbumin, albumin/creatinine ratio N[NN].N
Synonymous names:	Albumin/creatinine ratio
METeOR identifier:	270344
Registration status:	Health, Standard 01/03/2005
Definition:	The laboratory standard for the value of microalbumin measured as an albumin/creatinine ratio that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for microalbumin

Value domain attributes

Representational attributes

Representation class:	Ratio
Data type:	Number
Format:	N[NN].N
Maximum character length:	4
Supplementary values:	Value: 999.9 — Meaning: Not stated/inadequately described
Unit of measure:	Milligram per millimole (mg/mmol)
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the microalbumin normal reference range for the laboratory.
Collection methods:	Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay. Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority. As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate and if the albumin/creatinine ratio is found to be greater than 3.5mg/mmol then a timed overnight sample should be obtained for estimation of the albumin excretion rate.

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 Microalbumin - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.79 KB)

Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.27 KB)

See also Person—microalbumin level (measured), albumin/creatinine ratio N[NN].N Health, Standard 01/03/2005

Implementation in Data Set Specifications:

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

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

Information specific to this data set:

Microalbuminuria is a strong predictor of macrovascular disease and diabetic nephropathy. Incipient diabetic nephropathy can be detected by urine testing for microalbumin. Incipient diabetic nephropathy is suspected when microalbuminuria is detected in 2 of 3 samples collected over a 6-month period in patients in whom other causes of an increased urinary albumin excretion have been excluded.

Diagnosis of microalbuminuria is established if 2 of the 3 measurements are abnormal. A small amount of protein (albumin) in the urine (microalbuminuria) is an early sign of kidney damage.

If microalbuminuria is present:

- review diabetes control and improve if necessary
- consider treatment with Angiotensin-converting enzyme (ACE) inhibitor
- consider referral to a physician experienced in the care of diabetic renal disease

If macroalbuminuria is present:

- quantify albuminuria by measuring 24-hour urinary protein.
- refer to a physician experienced in the care of diabetic renal disease.

Microalbumin level—upper limit of normal range (micrograms per minute)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for microalbumin, total micrograms per minute N[NN].N
METeOR identifier:	270341
Registration status:	Health, Standard 01/03/2005
Definition:	The laboratory standard for the value of microalbumin measured in micrograms per minute (µg/min), that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for microalbumin

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN].N
Maximum character length:	4
Supplementary values:	Value: 999.9 — Meaning: Not stated/inadequately described
Unit of measure:	Microgram per minute (µg/min)
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the microalbumin normal reference range for the laboratory.
Collection methods:	Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay. Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority. As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate.

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 Microalbumin - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.79 KB)

Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.27 KB)

Implementation in Data Set Specifications:

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

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

Information specific to this data set:

Microalbuminuria is a strong predictor of macrovascular disease and diabetic nephropathy. Incipient diabetic nephropathy can be detected by urine testing for microalbumin. Incipient diabetic nephropathy is suspected when microalbuminuria is detected in 2 of 3 samples collected over a 6-month period in patients in whom other causes of an increased urinary albumin excretion have been excluded.

Diagnosis of microalbuminuria is established if 2 of the 3 measurements are abnormal. A small amount of protein (albumin) in the urine (microalbuminuria) is an early sign of kidney damage.

If microalbuminuria is present:

- review diabetes control and improve if necessary
- consider treatment with Angiotensin-converting enzyme (ACE) inhibitor
- consider referral to a physician experienced in the care of diabetic renal disease

If macroalbuminuria is present:

- quantify albuminuria by measuring 24-hour urinary protein.
- refer to a physician experienced in the care of diabetic renal disease.

Microalbumin level—upper limit of normal range (milligrams per 24 hour)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for microalbumin, total milligrams per 24 hour N[NN].N
METeOR identifier:	270343
Registration status:	Health, Standard 01/03/2005
Definition:	The laboratory standard for the value of microalbumin measured in milligrams per 24 hour, that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for microalbumin

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN].N
Maximum character length:	4
Supplementary values:	Value: 999.9 — Meaning: Not stated/inadequately described
Unit of measure:	Milligram per 24-hour period (mg/24h)
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the microalbumin normal reference range for the laboratory.
Collection methods:	Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay. Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority. As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate.

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 Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.27 KB)

Supersedes Microalbumin - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.79 KB)

Implementation in Data Set Specifications:

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

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

Information specific to this data set:

Microalbuminuria is a strong predictor of macrovascular disease and diabetic nephropathy. Incipient diabetic nephropathy can be detected by urine testing for microalbumin. Incipient diabetic nephropathy is suspected when microalbuminuria is detected in 2 of 3 samples collected over a 6-month period in patients in whom other causes of an increased urinary albumin excretion have been excluded.

Diagnosis of microalbuminuria is established if 2 of the 3 measurements are abnormal. A small amount of protein (albumin) in the urine (microalbuminuria) is an early sign of kidney damage.

If microalbuminuria is present:

- review diabetes control and improve if necessary
- consider treatment with Angiotensin-converting enzyme (ACE) inhibitor
- consider referral to a physician experienced in the care of diabetic renal disease

If macroalbuminuria is present:

- quantify albuminuria by measuring 24-hour urinary protein.
- refer to a physician experienced in the care of diabetic renal disease.

Microalbumin level—upper limit of normal range (milligrams per litre)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory standard—upper limit of normal range for microalbumin, total milligrams per litre N[NN].N
METeOR identifier:	270334
Registration status:	Health, Standard 01/03/2005
Definition:	The laboratory standard for the value of microalbumin measured in milligrams per litre (mg/L), that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for microalbumin

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
999.9	Not stated/inadequately described

Unit of measure:	Milligram per litre (mg/L)
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the microalbumin normal reference range for the laboratory.
Collection methods:	Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay. Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority. As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate.

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 Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.27 KB)

Supersedes Microalbumin - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.79 KB)

Implementation in Data Set Specifications:

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

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

Information specific to this data set:

Microalbuminuria is a strong predictor of macrovascular disease and diabetic nephropathy. Incipient diabetic nephropathy can be detected by urine testing for microalbumin. Incipient diabetic nephropathy is suspected when microalbuminuria is detected in 2 of 3 samples collected over a 6-month period in patients in whom other causes of an increased urinary albumin excretion have been excluded.

Diagnosis of microalbuminuria is established if 2 of the 3 measurements are abnormal. A small amount of protein (albumin) in the urine (microalbuminuria) is an early sign of kidney damage.

If microalbuminuria is present:

- review diabetes control and improve if necessary
- consider treatment with Angiotensin-converting enzyme (ACE) inhibitor
- consider referral to a physician experienced in the care of diabetic renal disease

If macroalbuminuria is present:

- quantify albuminuria by measuring 24-hour urinary protein.
- refer to a physician experienced in the care of diabetic renal disease.

Minutes of operating theatre time

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Admitted patient hospital stay—operating theatre time, total minutes NNNN
METeOR identifier:	270350
Registration status:	Health, Standard 01/03/2005
Definition:	Total time, in minutes, spent by a patient in operating theatres during current episode of hospitalisation.
Data Element Concept:	Admitted patient hospital stay—operating theatre time

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NNNN
Maximum character length:	4
Unit of measure:	Minute (m)

Collection and usage attributes

Collection methods:	Right justified, zero filled.

Data element attributes

Collection and usage attributes

Comments:	This metadata item was recommended for inclusion in the *National Health Data Dictionary* by *Hindle (1988a, 1988b)* to assist with diagnosis related group costing studies in Australia. This metadata item has not been accepted for inclusion in the National Minimum Data Set (NMDS) - Admitted patient care.

Source and reference attributes

Origin:	Health Data Standards Committee

Relational attributes

Related metadata references:	Supersedes Minutes of operating theatre time, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.33 KB)

Mode of admission

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—admission mode, code N
METeOR identifier:	269976
Registration status:	Health, Standard 01/03/2005
Definition:	The mechanism by which a person begins an episode of care, as represented by a code.
Data Element Concept:	Episode of admitted patient care—admission mode

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Admitted patient transferred from another hospital
2	Statistical admission - episode type change
3	Other

Collection and usage attributes

Guide for use:

CODE 2 Statistical admission - episode type change

Use this code where a new episode of care is commenced within the same hospital stay.

CODE 3 Other

Use this code for all planned admissions and unplanned admissions (except transfers into the hospital from another hospital).

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Mode of admission, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.06 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 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

Mode of separation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—separation mode, code N
METeOR identifier:	270094
Registration status:	Health, Standard 01/03/2005
Definition:	Status at **separation** of person (discharge/transfer/death) and place to which person is released, as represented by a code.
Data Element Concept:	Episode of admitted patient care—separation mode

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Discharge/transfer to (an)other acute hospital
2	Discharge/transfer to a residential aged care service, unless this is the usual place of residence
3	Discharge/transfer to (an)other psychiatric hospital
4	Discharge/transfer to other health care accommodation (includes mothercraft hospitals)
5	Statistical discharge - type change
6	Left against medical advice/discharge at own risk
7	Statistical discharge from leave
8	Died
9	Other (includes discharge to usual residence, own accommodation/welfare institution (includes prisons, hostels and group homes providing primarily welfare services))

Collection and usage attributes

Guide for use:

CODE 4 Discharge/transfer to other health care accommodation (includes mothercraft hospitals)

In jurisdictions where mothercraft facilities are considered to be acute hospitals, patients separated to a mothercraft facility should have a mode of separation of Code 1. If the residential aged care service is the patient's place of usual residence then they should have a mode of separation of Code 9.

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Mode of separation, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.29 KB)

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 – diagnosis related group, code (AR-DRG v5.1) ANNA 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

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

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

Morphology of cancer

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—morphology of cancer, code (ICDO-3) NNNN/N
METeOR identifier:	270179
Registration status:	Health, Standard 01/03/2005
Definition:	The histological classification of the cancer tissue (histopathological type) and a description of the course of development that a tumour is likely to take: benign or malignant (behaviour), as represented by a code.
Data Element Concept:	Person with cancer—morphology of cancer

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Diseases for Oncology 3rd edition
Representation class:	Code
Data type:	Number
Format:	NNNN/N
Maximum character length:	5

Collection and usage attributes

Guide for use:

ICDO morphology describes histology and behaviour as separate variables, recognising that there are a large number of possible combinations.

In ICDO, morphology is a 4-digit number ranging from 8000 to 9989, and behaviour is a single digit which can be 0, 1, 2, 3, 6 or 9.

Record morphology codes in accordance with ICDO coding standards. Use the 5th-digit to record behaviour. The 5th-digit behaviour code numbers used in ICDO are listed below:

0 Benign

1 Uncertain whether benign or malignant

- borderline malignancy
- low malignant potential

2 Carcinoma in situ

- intraepithelial
- non-infiltrating
- non-invasive

3 Malignant, primary site

6 Malignant, metastatic site

- malignant, secondary site

9 Malignant, uncertain whether primary or metastatic site

Source and reference attributes

Origin:	International Classification of Diseases for Oncology, Third Edition (ICDO-3)

Data element attributes

Collection and usage attributes

Collection methods:

Cancer registry use:

In cancer registries morphology information should be obtained from a pathology report or pathology system, and recorded with/on the patient's medical record and/or the hospital's patient administration system. Additional information may also be sought from the patient's attending clinician or medical practitioner.

Hospital morbidity use:

In hospitals, the morphology code is modified for use with ICD-10-AM. The morphology code consists of histologic type (4 digits) and behaviour code (1 digit) ranging from 8000/0 to 9989/9. The '/' between the fourth and fifth digits is not supplied.

Source and reference attributes

Origin:

World Health Organization

New South Wales Health Department

State and Territory Cancer Registries

Reference documents:

New South Wales Inpatient Statistics Collection Manual, 2000/2001

Esteban D, Whelan S, Laudico A and Parkin DM editors. International Agency for Research on Cancer World Health Organization and International Association of Cancer Registries: Manual for cancer registry personnel. IARC Technical Report No 10. Lyon: IARC,1995

Relational attributes

Related metadata references:

Supersedes Morphology of cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.26 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 information is collected for the purpose of:

- classifying tumours into clinically relevant groupings on the basis of both their morphology (cell type) and their degree of invasion or malignancy as indicated by the behaviour code component (the last digit of the morphology code);
- monitoring the number of new cases of cancer for planning treatment services.

Most common service delivery setting

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—most common service delivery setting, code N
METeOR identifier:	297708
Registration status:	Health, Standard 05/12/2007
Definition:	The setting in which the service provider organisation most commonly delivers services, as represented by a code.
Data Element Concept:	Service provider organisation—most common service delivery setting

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Mostly community-based setting
2	Mostly inpatient setting
3	Similar proportion in both settings

Collection and usage attributes

Collection methods:	Record only one code.

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Mostly community based setting

During the past 12 months, more than 60% of service delivery time was estimated to have been spent on delivering services to, and on behalf of, clients in community settings. This includes residential settings such as private residences (including caravans, mobile homes, houseboats or units in a retirement village), residential aged care facilities, prisons, and community living environments (including group homes); and non-residential settings such as day respite centres or day centres. It includes hospital outreach services and outpatient settings where these are delivered in the community setting.

CODE 2 Mostly inpatient setting

During the past 12 months, more than 60% of service delivery time was estimated to have been spent on delivering services to, and on behalf of, clients in inpatient settings. This includes hospitals, hospices or admitted patient settings. It excludes services delivered in outpatient settings and hospital outreach services delivered in the community setting.

	CODE 3 Similar level in both settings During the past 12 months, a similar proportion of service delivery time (between 40-60%) was estimated to have been spent on delivering services in community and inpatient settings.
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

Most valid basis of diagnosis of cancer

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—most valid basis of diagnosis of a cancer, code N
METeOR identifier:	270181
Registration status:	Health, Standard 01/03/2005
Definition:	The most valid basis of diagnosis of cancer, as represented by a code.
Data Element Concept:	Person with cancer—most valid basis of diagnosis of a cancer

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
0	Death certificate only: Information provided is from a death certificate
1	Clinical: Diagnosis made before death, but without any of the following (codes 2-7)
2	Clinical investigation: All diagnostic techniques, including x-ray, endoscopy, imaging, ultrasound, exploratory surgery (e.g. laparotomy), and autopsy, without a tissue diagnosis
4	Specific tumour markers: Including biochemical and/or immunological markers that are specific for a tumour site
5	Cytology: Examination of cells from a primary or secondary site, including fluids aspirated by endoscopy or needle; also includes the microscopic examination of peripheral blood and bone marrow aspirates
6	Histology of metastasis: Histological examination of tissue from a metastasis, including autopsy specimens
7	Histology of a primary tumour: Histological examination of tissue from primary tumour, however obtained, including all cutting techniques and bone marrow biopsies; also includes autopsy specimens of primary tumour
8	Histology: either unknown whether of primary or metastatic site, or not otherwise specified

Supplementary values:

9	Unknown.

Collection and usage attributes

Guide for use:

CODES 1 - 4

Non-microscopic.

CODES 5 - 8

Microscopic.

CODE 9

Other.

Comments:

In a hospital setting this metadata item should be collected on the most valid basis of diagnosis at this admission. If more than one diagnosis technique is used during an admission, select the higher code from 1 to 8.

Data element attributes

Collection and usage attributes

Guide for use:

The most valid basis of diagnosis may be the initial histological examination of the primary site, or it may be the post-mortem examination (sometimes corrected even at this point when histological results become available). In a cancer registry setting, this metadata item should be revised if later information allows its upgrading.

When considering the most valid basis of diagnosis, the minimum requirement of a cancer registry is differentiation between neoplasms that are verified microscopically and those that are not. To exclude the latter group means losing valuable information; the making of a morphological (histological) diagnosis is dependent upon a variety of factors, such as age, accessibility of the tumour, availability of medical services, and, last but not least, upon the beliefs of the patient.

A biopsy of the primary tumour should be distinguished from a biopsy of a metastasis, e.g., at laparotomy; a biopsy of cancer of the head of the pancreas versus a biopsy of a metastasis in the mesentery. However, when insufficient information is available, Code 8 should be used for any histological diagnosis. Cytological and histological diagnoses should be distinguished.

Morphological confirmation of the clinical diagnosis of malignancy depends on the successful removal of a piece of tissue that is cancerous. Especially when using endoscopic procedures (bronchoscopy, gastroscopy, laparoscopy, etc.), the clinician may miss the tumour with the biopsy forceps. These cases must be registered on the basis of endoscopic diagnosis and not excluded through lack of a morphological diagnosis.

Care must be taken in the interpretation and subsequent coding of autopsy findings, which may vary as follows:

a) the post-mortem report includes the post-mortem histological diagnosis (in which case, one of the Histology codes should be recorded instead);

b) the autopsy is macroscopic only, histological investigations having been carried out only during life (in which case, one of the Histology codes should be recorded instead);

c) the autopsy findings are not supported by any histological diagnosis.

Source and reference attributes

Origin: International Agency for Research on Cancer
International Association of Cancer Registries

Relational attributes

Related metadata references: Supersedes Most valid basis of diagnosis of cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (46.95 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:
Knowledge of the basis of a diagnosis underlying a cancer code is one of the most important aids in assessing the reliability of cancer statistics.

Mother's original family name

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—mother's original family name, text [X(40)]
METeOR identifier:	270262
Registration status:	Health, Standard 01/03/2005 Community services, Standard 01/03/2005
Definition:	The original family name of the person's mother as reported by the person, as represented by text.
Data Element Concept:	Person—mother's original family name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(40)]
Maximum character length:	40

Data element attributes

Collection and usage attributes

Guide for use:	Mixed case should be used (rather than upper case only).
Collection methods:	See relevant paragraphs in the collection methods section of the metadata item Person (name)—family name, text X[X(39)].

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	National Health Data Committee National Community Services Data Committee Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Relational attributes

Related metadata references:	Supersedes Mother's original family name, version 2, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005.pdf (14.07 KB)
Implementation in Data Set Specifications:	Health care client identification Health, Superseded 04/05/2005 Health care client identification DSS Health, Standard 04/05/2005

Multi-disciplinary team status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient service event—multi-disciplinary team status, code N
METeOR identifier:	270104
Registration status:	Health, Standard 01/03/2005
Definition:	Whether a non-admitted patient service event involved a multi-disciplinary team, as represented by a code.
Data Element Concept:	Non-admitted patient service event—multi-disciplinary team status

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Non-admitted multi-disciplinary team patient service event
2	Other non-admitted patient service event

Data element attributes

Relational attributes

Related metadata references: Supersedes Multi-disciplinary team status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.68 KB)

Myocardial infarction (history)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—myocardial infarction (history), code N
METeOR identifier:	270285
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the individual has had a myocardial infarction, as represented by a code.
Data Element Concept:	Person—myocardial infarction

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Myocardial infarction - occurred in the last 12 months
2	Myocardial infarction - occurred prior to the last 12 months
3	Myocardial infarction - occurred both in and prior to the last 12 months
4	No history of myocardial infarction

Supplementary values:

Value	Meaning
9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Collection methods: Ask the individual if he/she has had a myocardial infarction. If so determine whether it was within or prior to the last 12 months (or both).Record if evidenced by ECG changes or plasma enzyme changes.
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.
Reference documents:	Long-term Results From the Diabetes and Insulin-Glucose Infusion in Acute Myocardial Infarction (DIGAMI) Study Circulation. 1999;99: 2626-2632.

Relational attributes

Related metadata references: Supersedes Myocardial infarction - history, version 1, DE,

NHDD, NHIMG, Superseded 01/03/2005.pdf (16.68 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:

Myocardial infarction (MI) generally occurs as a result of a critical imbalance between coronary blood supply and myocardial demand. Decrease in coronary blood flow is usually due to a thrombotic occlusion of a coronary artery previously narrowed by atherosclerosis. MI is one of the most common diagnoses in hospitalised patients in industrialised countries.

The most widely used in the detection of MI are creatinine kinase (CK) and (CK-MB), aspartate aminotransferase (AST) and lactate dehydrogenase (LD). Characteristic ECG changes include ST elevation, diminution of the R wave and a Q wave development. A recent study on Diabetes and Insulin-Glucose Infusion in Acute Myocardial Infarction (DIGAMI study) indicated that in diabetic patients with AMI, mortality is predicted by age, previous heart failure, and severity of the glycometabolic state at admission, but not by conventional risk factors or sex (American Heart Association 1999).

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

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

Name context flag

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (name)—name conditional use flag, code N
Synonymous names:	Name conditional use flag
METeOR identifier:	287101
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005
Definition:	An indicator of specific conditions that may be applied to an individual's name, as represented by a code.
Data Element Concept:	Person (name)—name conditional use flag

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Unreliable information
2	Name not for continued use
3	Special privacy/security requirement

Data element attributes

Collection and usage attributes

Guide for use:

A single Person name may have multiple Name conditional use flags associated with it. Record as many as applicable.

Code 1 - Unreliable information: should be used where it is known that the name recorded is a fictitious or partial name. These names should not be used for matching client data.

Code 2 - Name not for continued use, indicates that this name should NOT be used when referring to this person. The name is retained for identification purposes only. For Aboriginal and Torres Strait Islanders, certain tribal names may become 'not for continued use' due to the death of a relative.

Code 3 – Special privacy/security requirements– may apply to names for which episodes are attached that should only be accessible to specified authorised persons. There must be a specific need to implement this additional security level. Local policy should provide guidance to the use of this code.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	National Health Data Committee

	National Community Services Data Committee
	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:	Supersedes Person (name) — name context flag, code N Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005
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

Name suffix

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (name)—name suffix, text [A(12)]
METeOR identifier:	287164
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005
Definition:	Additional term following a person's name used to identify a person when addressing them by name, whether by mail, by phone, or in person, as represented by text.
Data Element Concept:	Person (name)—name suffix

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[A(12)]
Maximum character length:	12

Collection and usage attributes

Guide for use:	Valid abbreviations from the Australian Standard AS4590-1999 Interchange of client information.

Source and reference attributes

Origin:	Standards Australia 1999. Australian Standard AS4590-1999 Interchange of Client Information. Sydney: Standards Australia Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Data element attributes

Collection and usage attributes

Guide for use:	Mixed case should be used (rather than upper case only). Examples of name suffixes are 'Jr' for Junior and 'MP' for Member of Parliament.
Collection methods:	A person's name may have multiple Name suffixes. For the purpose of positive identification of a person, each Name suffix must have an associated Name suffix sequence number recorded.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	National Health Data Committee National Community Services Data Committee
Reference documents:	AS4846 Health Care Provider Identification, 2004, Sydney:Standards Australia

Relational attributes

Related metadata references:	Supersedes Person (name)—name suffix, text [A(12)] Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005
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

Name suffix sequence number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (name)—name suffix sequence number, code N
METeOR identifier:	288226
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The numeric order of any additional terms used at the conclusion of a name, as represented by a code.
Data Element Concept:	Person (name)—name suffix sequence number

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	First name suffix
2	Second name suffix
3	Third name suffix
4	Fourth name suffix
5	Fifth name suffix
6	Sixth name suffix
7	Seventh name suffix
8	Eighth name suffix
9	Ninth and subsequent name suffix

Data element attributes

Collection and usage attributes

Collection methods:

Multiple Name suffixes may be recorded. A Name suffix sequence number must be recorded for each Name suffix.

Example: For the name 'John Markham Jr MP', 'Jr' would have a name suffix sequence number of 1 and 'MP' would have a name suffix sequence number of 2.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

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

Name title

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (name)—name title, text [A(12)]
METeOR identifier:	287166
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005
Definition:	An honorific form of address, commencing a name, used when addressing a person by name, whether by mail, by phone, or in person, as represented by text.
Data Element Concept:	Person (name)—name title

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	A(12)
Maximum character length:	12

Collection and usage attributes

Guide for use:	Valid abbreviations from the Australian Standard AS4590-1999 Interchange of client information.

Source and reference attributes

Origin:	Standards Australia 1999. Australian Standard AS4590-1999 Interchange of Client Information. Sydney: Standards Australia Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Data element attributes

Collection and usage attributes

Guide for use:	Mixed case should be used (rather than upper case only). The Name title for Master should only be used for persons less than 15 years of age. Name titles for Doctor and Professor should only be applicable to persons of greater than 20 years of age. More than one Name title may be recorded eg Prof Sir John Markham.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	National Health Data Committee National Community Services Data Committee Standards Australia 1999. Australian Standard AS4590-1999 Interchange of Client Information. Sydney: Standards Australia 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: Supersedes Person (name) — name title, text [A(12)] Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005

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

Information specific to this data set:

For the purpose of positive identification of a person, each name title should be associated with a Name title sequence number.

Name title should not be confused with job title. An example of Name title is 'Mr' for Mister.

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:

For the purpose of positive identification of a person, each name title should be associated with a Name title sequence number.

Name title should not be confused with job title. An example of Name title is 'Mr' for Mister.

Name title sequence number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (name)—name title sequence number, code N
METeOR identifier:	288263
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The numeric order of an honorific form of address commencing a person's name, as represented by a code.
Data Element Concept:	Person (name)—name title sequence number

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	First name title
2	Second name title
3	Third name title
4	Fourth name title
5	Fifth name title
6	Sixth name title
7	Seventh name title
8	Eighth name title
9	Ninth and subsequent name title

Data element attributes

Collection and usage attributes

Collection methods:

Multiple Name titles may be recorded. For the purpose of positive identification of a person, each Name title must have a Name title sequence number recorded.

Example: Professor Sir John Markham

In the example above 'Professor' would have a name title sequence number of 1 and 'Sir' would have a name title sequence number of 2.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

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

Name type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (name)—name type, code N
METeOR identifier:	287203
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	A classification that enables differentiation between recorded names for a person, as represented by a code.
Data Element Concept:	Person (name)—name type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Preferred name
2	Medicare name
3	Newborn name
4	Alias name

Data element attributes

Collection and usage attributes

Guide for use:

A person may have more than one name that they use. At least one name must be recorded for each person. Each name recorded must have one or more appropriate Person name type associated with it. Record all that are required.

One name is sufficient, however, where the person offers more than one name, clarification should be obtained from the person to ensure accurate identification of the person and recording of the various names. The currently used name, as well as names by which the person has previously been known, should be recorded if these are known.

Field value definitions for Person name type codes are:

Code 1 - Preferred name is the name by which the person chooses to be identified.
There should only be one preferred name recorded for a person. Where the person changes their preferred name, record the previously recorded preferred name as an Alias name.
Preferred name is the default name type (i.e. if only one name is recorded it should be the person's preferred name). There must be a preferred name recorded except for unnamed newborns where the newborn name is the only name recorded.
Also, if the person is a health care client, record his/her Medicare card name if different to the preferred name, and any

known alias names.

Code 2 - Medicare name For a health care client, this is the person's name as it appears on their Medicare card. The name stated on the Medicare card is required for all electronic Medicare claim lodgement. If the preferred name of the person is different to the name on the Medicare card, the Medicare card name should also be recorded. For an individual health care provider, this is the person's name registered by Medicare (Health Insurance Commission).

Code 3 - Newborn name: type is reserved for the identification of unnamed newborn babies.

Code 4 - Alias name is any other name that a person is also known by, or has been known by in the past; that is, all alias names. This includes misspelt names or name variations that are to be retained as they have been used to identify this person. More than one alias name may be recorded for a person.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	National Health Data Committee National Community Services Data Committee AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia
Reference documents:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia In AS5017 and AS4846 alternative alphabetic codes are presented. Refer to the current standard for more details.

Relational attributes

Related metadata references:	Supersedes Person (name)—name type, code A 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

Name type (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (name)—name type, code N
METeOR identifier:	288937
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	A classification that enables differentiation between recorded names for an establishment, agency or organisation, as represented by a code.
Data Element Concept:	Service provider organisation (name)—name type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Organisation unit/section/division
2	Service location name
3	Business name
4	Locally used name
5	Abbreviated name
6	Enterprise name
8	Other

Supplementary values:

9	Unknown

Collection and usage attributes

Guide for use:

CODE 1 Organisation unit/section/division

This code is used where a business unit, section or division within an organisation may have its own separate identity.

CODE 2 Service location name

This code is used where the service location name is an important part of the organisation name and is used for identification purposes, e.g. Mobile Immunisation Unit at Bankstown.

CODE 3 Business name

Business name used only for trading purposes.

CODE 4 Locally used name

This code is used where a local name is used, e.g. where a medical practice is known by a name that is different to the company registration name or business name.

CODE 5 Abbreviated name

A short name or an abbreviated name by which the organisation is known, e.g. HIC.

CODE 6 Enterprise name

Generally, the complete organisation name should be used to avoid any ambiguity in identification. This should usually be the same as company registration name.

CODE 8 Other

This code is used when the organisation name does not fit into any one of the categories listed above.

CODE 9 Unknown

This code is used when the organisation name type is unknown.

Data element attributes

Collection and usage attributes

Guide for use:

At least one organisation name must be recorded for each organisation and each name must have an appropriate Organisation name type.

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

Narrative description of injury event

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—external cause, text [X(100)]
METeOR identifier:	268946
Registration status:	Health, Standard 01/03/2005
Definition:	A textual description of the environmental event, circumstance or condition as the cause of injury, poisoning and other adverse effect.
Data Element Concept:	Injury event—external cause

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(100)]
Maximum character length:	100

Data element attributes

Collection and usage attributes

Guide for use:	Write a brief description of how the injury occurred. It should indicate what went wrong (the breakdown event); the mechanism by which this event led to injury; and the object(s) or substance(s) most important in the event. The type of place at which the event occurred, and the activity of the person who was injured should be indicated.
Comments:	The narrative of the injury event is very important to injury control workers as it identifies features of the event not revealed by coded data. This is a basic item for injury surveillance. The text description of the injury event is structured to indicate context, place, what went wrong and how the event resulted in injury. Further information on the national injury surveillance program can be obtained from the National Injury Surveillance Unit, Flinders University, Adelaide.

Source and reference attributes

Submitting organisation:	National Injury Surveillance Unit, Flinders University, Adelaide

Relational attributes

Related metadata references:	Supersedes Narrative description of injury event, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.35 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

National standards for mental health services review status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service unit—implementation of National standards for mental health services status, code N
METeOR identifier:	287800
Registration status:	Health, Standard 08/12/2004
Definition:	The extent of progress made by a specialised mental health service unit in implementing the National Standards for Mental Health Services by or at 30 June, as represented by a code.
Data Element Concept:	Specialised mental health service unit—implementation of National standards for mental health services status

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	The service unit had been reviewed by an external accreditation agency and was judged to have met the National standards
2	The service unit had been reviewed by an external accreditation agency and was judged to have met some but not all of the National standards
3	The service unit was in the process of being reviewed by an external accreditation agency but the outcomes were not known
4	The service unit was booked for review by an external accreditation agency and was engaged in self-assessment preparation prior to the formal external review
5	The service unit was engaged in self-assessment in relation to the National Standards but did not have a contractual arrangement with an external accreditation agency for review
6	The service unit had not commenced the preparations for review by an external accreditation agency but this was intended to be undertaken in the future
7	It had not been resolved whether the service unit would undertake review by an external accreditation agency under the National standards

8	The National standards are not applicable to this service unit

Collection and usage attributes

Guide for use:

Code 8 The National standards are not applicable to this service unit

This code should only be used for:

- non-government organisation mental health services and private hospitals (that receive some government funding to provide specialised mental health services) where implementation of National standards for mental health services has not been agreed with the relevant state or territory; or
- those aged care residential services (e.g. psychogeriatric nursing homes) in receipt of funding under the *Aged Care Act* and subject to Commonwealth residential aged care reporting and service standards requirements.

Data element attributes

Collection and usage attributes

Collection methods:

Report the review/accreditation status at 30 June for each service unit for the National standards for mental health services using the standard set of codes shown in the value domain.

For organisations that include more than one service unit the codes relating to each service should be completed. Reporting of progress at the individual service unit level recognises that parts rather than whole organisations may be implementing the standards.

NOTE: for admitted patient setting only, these data need to be disaggregated by specialised mental health service program type and specialised mental health service target population.

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:

Obligation condition: 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.

Nature of main injury (non-admitted patient)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—nature of main injury, non-admitted patient code NN{.N}
METeOR identifier:	268947
Registration status:	Health, Standard 01/03/2005
Definition:	The nature of the injury chiefly responsible for the attendance of the non-admitted patient at the health care facility, at represented by a code.
Data Element Concept:	Injury event—nature of main injury

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN{.N}
Maximum character length:	4

Permissible values:

Value	Meaning
01	Superficial (excludes eye injury code 13)
02	Open wound (excludes eye injury code 13)
03	Fracture (excludes dental injury code 21)
04	Dislocation (includes ruptured disc, cartilage, ligament)
05	Sprain or strain
06	Injury to nerve (includes spinal cord; excludes intracranial injury code 20)
07	Injury to blood vessel
08	Injury to muscle or tendon
09	Crushing injury
10	Traumatic amputation (includes partial amputation)
11	Injury to internal organ
12	Burn or corrosion (excludes eye injury code 13)
13	Eye injury (includes burns, excludes foreign body in external eye code 14.1)
14.1	Foreign body in external eye
14.2	Foreign body in ear canal
14.3	Foreign body in nose
14.4	Foreign body in respiratory tract (excludes foreign body in nose code 14.3)
14.5	Foreign body in alimentary tract
14.6	Foreign body in genitourinary tract
14.7	Foreign body in soft tissue

14.9	Foreign body, other/unspecified
20	Intracranial injury (includes concussion)
21	Dental injury (includes fractured tooth)
22	Drowning, immersion
23	Asphyxia or other threat to breathing (excludes drowning immersion code 22)
24	Electrical injury
25	Poisoning, toxic effect (excludes effect of venom, or any insect bite code 26)
26	Effect of venom, or any insect bite
27	Other specified nature of injury
28	Injury of unspecified nature
29	Multiple injuries of more than one 'nature'
30	No injury detected

Data element attributes

Collection and usage attributes

Guide for use:

If the full ICD-10-AM code is used to code the injury, this metadata item is not required (see metadata items principal diagnosis and additional diagnosis) When coding to the full ICD-10-AM code is not possible, use this metadata item with the items external cause of injury-non admitted patient, external cause of injury-human intent and bodily location of main injury.

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

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

Comments:

Injury diagnosis is necessary for purposes including epidemiological research, casemix studies and planning. This metadata item together with the metadata item bodily location of the main injury indicates the diagnosis.

This metadata item is related to the ICD-10-AM injury and poisoning classification. However, coding to the full ICD-10-AM injury and poisoning classification (see metadata item principal diagnosis) is not available in most settings where basic injury surveillance is undertaken. This item, in combination with the metadata item Bodily location of main

injury, is a practicable alternative. Data coded to the full ICD-10-AM codes can be aggregated to match this item, facilitating data comparison. Further information on the national injury surveillance program can be obtained from the National Injury Surveillance Unit, Flinders University, Adelaide.

Source and reference attributes

Submitting organisation:

National Injury Surveillance Unit, Flinders University, Adelaide

National Data Standards for Injury Surveillance Advisory Group

Relational attributes

Related metadata references:

Supersedes Nature of main injury - non-admitted patient, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.3 KB)

Implementation in Data Set Specifications:

Injury surveillance DSS Health, Superseded 05/02/2008

Injury surveillance DSS Health, Standard 05/02/2008

Information specific to this data set:
Left justified, zero filled.

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

Neonatal morbidity

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Admitted patient (neonate)—neonatal morbidity, code (ICD-10-AM 6th edn) ANN{.N[N]}
METeOR identifier:	361928
Registration status:	Health, Standard 05/02/2008
Definition:	Conditions or diseases of the baby, as represented by an ICD-10-AM code.
Data Element Concept:	Admitted patient (neonate)—neonatal morbidity

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

Collection and usage attributes

Guide for use:	Conditions should be coded within chapter of Volume 1, ICD-10-AM.

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Admitted patient (neonate)—neonatal morbidity, code (ICD-10-AM 5th edn) ANN{.N[N]} Health, Superseded 05/02/2008

Net capital expenditure (accrual accounting)—buildings and building services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (buildings and building services) (financial year), total Australian currency N[N(8)]
METeOR identifier:	269969
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure, measured in Australian dollars, on buildings and building services (including plant).
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (buildings and building services)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.21 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

Net capital expenditure (accrual accounting)—constructions

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (constructions) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270531
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure, measured in Australian dollars, on constructions (other than buildings).
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (constructions)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.21 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

Net capital expenditure (accrual accounting)—equipment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (equipment) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270534
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure, measured in Australian dollars, on equipment.
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (equipment)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.21 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

Net capital expenditure (accrual accounting)—information technology

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (information technology) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270529
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure, measured in Australian dollars, on information technology.
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (information technology)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.21 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

Net capital expenditure (accrual accounting)—intangible assets

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (intangible assets) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270535
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure, measured in Australian dollars, on intangible assets.
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (intangible assets)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.21 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

Net capital expenditure (accrual accounting)—land

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (land) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270536
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure, measured in Australian dollars, on land.
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (land)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.21 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

Net capital expenditure (accrual accounting)—major medical equipment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (major medical equipment) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270530
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure, measured in Australian dollars, on major medical equipment.
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (major medical equipment)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.21 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

Net capital expenditure (accrual accounting)—other equipment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (other equipment) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270533
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure, measured in Australian dollars, on other equipment, such as furniture, art objects, professional instruments and containers.
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (other equipment)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.21 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

Net capital expenditure (accrual accounting)—transport

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—net capital expenditure (accrual accounting) (transport) (financial year), total Australian currency N[N(8)]
METeOR identifier:	270532
Registration status:	Health, Standard 01/03/2005
Definition:	Net capital expenditure measured in Australian dollars on transport.
Data Element Concept:	Establishment—net capital expenditure (accrual accounting) (transport)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.21 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

New/repeat status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient service event—new/repeat status, code N
METeOR identifier:	270348
Registration status:	Health, Standard 01/03/2005
Definition:	Whether a non-admitted patient service event is for a new problem not previously addressed at the same clinical service or for a repeat service event, as represented by a code.
Data Element Concept:	Non-admitted patient service event—new/repeat service event status

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	New non-admitted patient service event
2	Repeat non-admitted patient service event

Collection and usage attributes

Guide for use:

CODE 1 New non-admitted patient service event:

New service events occur as each type of clinical service makes their full assessment consultation with the patient.

CODE 2 Repeat non-admitted patient service event:

Repeat visits include completion of an ambulatory procedure e.g. removal of sutures and removal of plaster casts.

Data element attributes

Relational attributes

Related metadata references: Supersedes New/repeat status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.37 KB)

Non-Australian state/province (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—non-Australian state/province, text [X(40)]
METeOR identifier:	288648
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The designation applied to an internal, political or geographic division of a country other than Australia that is officially recognised by that country that is associated with the address of a person, as represented by text.
Data Element Concept:	Person (address)—non-Australian state/province

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(40)]
Maximum character length:	40

Data element attributes

Collection and usage attributes

Guide for use:	The name of the state or territory or province should be recorded using the standard ASCII character set and should be done so in accordance with the official conventions of the country.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare Standard Australia
Origin:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

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:* When used for identification purposes record this data element as part of an address.

Non-Australian state/province (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—non-Australian state/province, text [X(40)]
METeOR identifier:	288636
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The designation applied to an internal, political or geographic division of a country other than Australia that is officially recognised by that country that is associated with the address of an establishment, as represented by text.
Data Element Concept:	Service provider organisation (address)—non-Australian state/province

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(40)]
Maximum character length:	40

Data element attributes

Collection and usage attributes

Guide for use:	The name of the state or territory or province should be recorded using the standard ASCII character set and should be done so in accordance with the official conventions of the country.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

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:* When used for identification purposes record this data element as part of an address.

Non-admitted patient emergency department service episode—triage category, code N

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—triage category, code N
Synonymous names:	Triage category
METeOR identifier:	270078
Registration status:	Health, Standard 01/03/2005
Definition:	The urgency of the patient's need for medical and nursing care, as represented by a code.
Data Element Concept:	Non-admitted patient emergency department service episode—triage category

Value domain attributes

Representational attributes

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

Permissible values:

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

Data element attributes

Collection and usage attributes

Collection methods:

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

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

Source and reference attributes

Origin:	National Triage Scale, Australasian College for Emergency Medicine

Relational attributes

Related metadata references:	Supersedes Triage category, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.26 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

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

Number of available beds for admitted patients

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of available beds for admitted patients/residents, average N[NNN]
METeOR identifier:	270133
Registration status:	Health, Standard 01/03/2005
Definition:	The average number of beds which are immediately available for use by an admitted patient or **resident** within the establishment. A bed is immediately available for use if it is located in a suitable place for care with nursing and auxiliary staff available within a reasonable period.
Data Element Concept:	Establishment—number of available beds for admitted patients/residents

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	N[NNN]
Maximum character length:	4
Unit of measure:	Bed

Collection and usage attributes

Guide for use:	Average available beds, rounded to the nearest whole number.

Data element attributes

Collection and usage attributes

Guide for use:	The average bed is to be calculated from monthly figures.
Comments:	This metadata item was amended during 1996-97. Until then, both average and end-of-year counts of available beds were included, and the end-of-year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate characterisation of establishments and comparisons.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Number of available beds for admitted patients, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.24 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

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:

These data are to be disaggregated by specialised mental health service setting (excluding ambulatory care). For the admitted patient care setting these records are to be disaggregated by specialised mental health service program type and specialised mental health service target population.

For the Mental health establishments national minimum data set, available beds are restricted to available beds that are intended for overnight stays only. That is, beds that are only available for same day stays are not included in the count.

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

Number of caesarean sections

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—number of caesarean sections, total count N[N]
METeOR identifier:	297820
Registration status:	Health, Standard 29/11/2006
Definition:	The total number of previous caesarean sections performed on the woman.
Data Element Concept:	Female—number of caesarean sections

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]
Maximum character length:	2

Supplementary values:

Value	Meaning
99	Not stated/Inadequately described

Proposed unit of measure: Caesarean sections

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Data element attributes

Collection and usage attributes

Guide for use:	In the case of multiple births, count the number of operations the mother has had, rather than the number of babies born. Exclude the current birth if by caesarean section. Record as 0 if no previous caesarean sections.
Comments:	Previous caesarean sections are associated with a higher risk of obstetric complications, and when used with other indicators provides important information on the quality of obstetric care.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Number of contacts—psychiatric outpatient clinic/day program

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—number of psychiatric outpatient clinic/day program attendances (financial year), total days N[NN]
METeOR identifier:	270121
Registration status:	Health, Standard 01/03/2005
Definition:	Number of days that a patient attended a psychiatric outpatient clinic or a day program during the relevant financial year.
Data Element Concept:	Patient—number of psychiatric outpatient clinic/day program attendances

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Collection methods:	All States and Territories where there are public psychiatric hospitals also collect date of contact, and number of contacts during the financial year can be derived from this. (Collection status for New South Wales is unknown at time of writing.)
Comments:	This metadata item gives a measure of the level of service provided. In December 1998, the National Health Information Management Group decided that the new version of this metadata item (named Person—number of service contact dates, total N[NN]) would be implemented from 1 July 2000 in the Community Mental Health National Minimum Data Set (NMDS). Until then agencies involved in the Community mental health NMDS may report either Patient—number of psychiatric outpatient clinic/day program attendances (financial year), total days N[NN] or Person—number of service contact dates, total N[NN] with the expectation that agencies will make their best efforts to report against the new version of this metadata item (Person—number of service contact dates, total N[NN]) from 1 July 1999.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Number of contacts (psychiatric outpatient clinic/day program), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB)

Number of days in special/neonatal intensive care

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—length of stay (special/neonatal intensive care), total days N[NN]
METeOR identifier:	270057
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of days spent by a neonate in a special care or neonatal intensive care nursery (in the hospital of birth).
Data Element Concept:	Episode of admitted patient care—length of stay (special/neonatal intensive care)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:	The number of days is calculated from the date the baby left the special/neonatal **intensive care unit** minus the date the baby was admitted to the special/neonatal intensive care unit.
Collection methods:	This item is to be completed if baby has been treated in an intensive care unit or a special care nursery (SCN).
Comments:	An indicator of the requirements for hospital care of high-risk babies in specialised nurseries that add to costs because of extra staffing and facilities. SCN are staffed and equipped to provide a full range of neonatal services for the majority of complicated neonatal problems, including short-term assisted ventilation and intravenous therapy. Neonatal intensive care nurseries (NICN) are staffed and equipped to treat critically ill newborn babies including those requiring prolonged assisted respiratory support, intravenous therapy, and alimentation and treatment of serious infections. Full supportive services are readily available throughout the hospital. These NICN also provide consultative services to other hospitals.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Number of days in special / neonatal intensive

care, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.9 KB)

Number of days of hospital-in-the-home care

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—number of days of hospital-in-the-home care, total {N[NN]}
METeOR identifier:	270305
Registration status:	Health, Standard 01/03/2005
Definition:	The number of **hospital-in-the-home** days occurring within an episode of care for an admitted patient.
Data Element Concept:	Episode of admitted patient care—number of days of hospital-in-the-home care

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	{N[NN]}
Maximum character length:	3
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:

The rules for calculating the number of **hospital-in-the-home** days are outlined below:

- The number of hospital-in-the-home days is calculated with reference to the date of admission, date of separation, leave days and any date(s) of change between hospital and home accommodation;
- The date of admission is counted if the patient was at home at the end of the day;
- The date of change between hospital and home accommodation is counted if the patient was at home at the end of the day;
- The date of separation is not counted, even if the patient was at home at the end of the day;
- The normal rules for calculation of patient days apply, for example in relation to leave and same day patients.

Comments:

Number of days of hospital-in-the-home care data will be collected from all states and territories except Western Australia from 1 July 2001. Western Australia will begin to collect data from a later date.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Number of days of hospital-in-the-home care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15 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 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

Number of episodes of residential care

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of residential care—number of episodes of residential care, total N[NNN]
METeOR identifier:	287957
Registration status:	Health, Standard 08/12/2004
Definition:	The total number of episodes of completed residential care occurring during the reference period (between 1 July and 30 June each year). This includes both formal and statistical episodes of residential care.
Data Element Concept:	Episode of residential care—number of episodes of residential care

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

The sum of the number of episodes of residential care where the Episode of residential care end date has a value:

- Equal to or greater than the beginning of the reference period (01 July each year); and
- Less than or equal to the end of the reference period (30 June each year at midnight).

Collection methods:

To be reported for all specialised residential mental health care services, including non-government residential mental health care services and

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

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

Number of group sessions

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group sessions, total N[NNNNN]
Synonymous names:	Group occasions of service
METeOR identifier:	336900
Registration status:	Health, Standard 04/07/2007
Definition:	The total number of groups of patients receiving services. Each group is to be counted once, irrespective of the size of the group of patients or the number of staff providing services.
Data Element Concept:	Establishment—number of group sessions

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNN]
Maximum character length:	6
Unit of measure:	Group session

Data element attributes

Collection and usage attributes

Guide for use:

A group is defined as two or more patients receiving the same services at the same time from the same hospital staff at the same clinics.

The following guides for use apply:

- a group session is counted only for two or more patients attending in the capacity of patients in their own right, even if other non-patient persons are present for the service.
- Spouses, parents or carers attending the session are counted for the group session only if they are also participating in the service as a patient.
- A group session is counted for staff attending clinics only if they are attending as a patient in their own right. Staff training and education is excluded.
- A group session may be delivered by more than one provider. A group session is counted for two or more patients receiving the same services, even if more than one provider delivers that service simultaneously.
- Patients attending for treatment at a dialysis or a chemotherapy clinic are receiving individual services. Patients attending education sessions at chemotherapy or dialysis clinics are counted as group sessions, if two or more people are receiving the same services at the same time.

Collection methods:

Where a patient receives multidisciplinary care within one booked clinic appointment as part of a group, one group

session shall be recorded, regardless of the number of providers involved. For example, if a group session is jointly delivered by a physiotherapist and an occupational therapist, one group session is counted for the patients attending that session.

Source and reference attributes

Submitting organisation: Non-admitted patient NMDS Development Working Party, 2006

Relational attributes

Related metadata references: Supersedes Establishment—number of group sessions, total N[NNNNN] Health, Superseded 04/07/2007

Implementation in Data Set Specifications: Outpatient care NMDS Health, Standard 04/07/2007

Implementation start date: 01/07/2007

Number of leave periods

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—number of leave periods, total N[N]
METeOR identifier:	270058
Registration status:	Health, Standard 01/03/2005
Definition:	Number of leave periods in a hospital stay (excluding one-day leave periods for admitted patients).
Data Element Concept:	Episode of admitted patient care—number of leave periods

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]
Maximum character length:	2
Unit of measure:	Period

Data element attributes

Collection and usage attributes

Guide for use:	If the period of leave is greater than seven days or the patient fails to return from leave, the patient is discharged.
Comments:	Recording of leave periods allows for the calculation of patient days excluding leave. This is important for analysis of costs per patient and for planning. The maximum limit allowed for leave affects admission and **separation** rates, particularly for long-stay patients who may have several leave periods. This data element was modified in July 1996 to exclude the previous differentiation between the psychiatric and other patients at the instigation of the National Mental Health Strategy Committee.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Number of leave periods, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.46 KB) Is used in the formation of Episode of admitted patient care—length of stay (excluding leave days), total N[NN] Health, Standard 01/03/2005

Number of occasions of service

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of occasions of service, total N[NNNNNN]
Synonymous names:	Individual occasions of service
METeOR identifier:	336947
Registration status:	Health, Standard 04/07/2007
Definition:	The total number of occasions of examination, consultation, treatment or other service provided to a patient.
Data Element Concept:	Establishment—number of occasions of service

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Guide for use:

The following guides for use apply:

- an occasion of service is counted for each person attending in the capacity of a patient in their own right, even if other non-patient persons are present for the service.
- spouses, parents or carers attending the session are only counted if they are also participating in the service as a patient.
- in the instance of a dependent child presenting to a clinic, the session is counted as a single Occasion of Service provided to the individual child for whom an event history is being recorded. Where parents/carers also attend in the capacity of patients themselves within a booked appointment, and receive the same services at the same time, the child and parent/carer can be counted as a group. In this instance a Group Session count would be recorded.
- An occasion of service is counted for staff attending clinics of public hospitals only if they are attending as patients in their own right. Staff education and training is excluded.
- Patients attending for treatment at a dialysis or a chemotherapy clinic are receiving individual services. Patients attending education sessions at chemotherapy or dialysis clinics are counted as group sessions, if two or more people receiving the same services at the same time.

Collection methods:

- Where a patient receives the occasion of service is counted at the clinic of the public hospital where the patient is

booked.

- Where a patient receives multidisciplinary care, within one booked clinic appointment by themselves, one occasion of service shall be recorded, regardless of the number of providers involved.
- Where patients have received more than one booked appointment, each appointment will be counted as one occasion of service. (Example: three booked appointments with all services provided on a single day will be counted as three occasions of service).
- The occasion of service count should be attributed to the clinic type associated with the booked appointment.
- Services to individual patients should be counted separately from services to groups of patients. An occasion of service is counted only for a service provided to an individual. Group sessions are reported separately under 'Establishment - number of group sessions total N[NNNNNN]'.

Source and reference attributes

Submitting organisation: Non-admitted patient NMDS Development Working Party, 2006

Relational attributes

Related metadata references: See also Establishment—outpatient clinic type, code N[N] Health, Standard 04/07/2007

Supersedes Establishment—number of occasions of service, total N[NNNNNN] Health, Superseded 04/07/2007

Implementation in Data Set Specifications: Outpatient care NMDS Health, Standard 04/07/2007

Implementation start date: 01/07/2007

Number of qualified days for newborns

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care (newborn)—number of qualified days, total N[NNNN]
METeOR identifier:	270033
Registration status:	Health, Standard 01/03/2005
Definition:	The number of qualified newborn days occurring within a newborn episode of care.
Data Element Concept:	Episode of admitted patient care (newborn)—number of qualified days

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

The rules for calculating the number of qualified newborn days are outlined below. The number of qualified days is calculated with reference to the Episode of admitted patient care—admission date, DDMMYYYY, Episode of admitted patient care—separation date, DDMMYYYY and any Episode of admitted patient care (newborn)—date of change to qualification status, DDMMYYYY:

- the date of admission is counted if the patient was qualified at the end of the day
- the date of change to qualification status is counted if the patient was qualified at the end of the day
- the date of separation is not counted, even if the patient was qualified on that day
- the normal rules for calculation of patient days apply, for example in relation to leave and same day patients

The length of stay for a newborn episode of care is equal to the sum of the qualified and unqualified days.

Relational attributes

Related metadata references:

Supersedes Number of qualified days for newborns, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.53 KB)

Is formed using Episode of admitted patient care (newborn)—date of change to qualification status, DDMMYYYY Health, Standard 01/03/2005

Is used in the formation of Establishment—number of patient

days, total N[N(7)] 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

Number of service contact dates

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—number of service contact dates, total N[NN]
METeOR identifier:	270231
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of dates where a service contact was recorded for the patient/client.
Data Element Concept:	Person—number of service contact dates

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Service contact date

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item is a count of service contact dates recorded on a patient or client record. Where multiple service contacts occur on the same date, the date is counted only once. For collection from community-based (ambulatory and non-residential) agencies. Includes mental health day programs and psychiatric outpatients.
Comments:	This metadata item gives a measure of the level of service provided to a patient/client.

Source and reference attributes

Submitting organisation:	National Mental Health Information Strategy Committee

Relational attributes

Related metadata references:	Is formed using Service contact—service contact date, DDMMYYYY Health, Standard 01/03/2005 Supersedes Number of service contact dates, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.91 KB)

Number of service contacts within a treatment episode for alcohol and other drug

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—number of service contacts, total N[NN]
METeOR identifier:	270117
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of service contacts recorded between a client and the service provider within a treatment episode for the purpose of providing alcohol and other drug treatment.
Data Element Concept:	Episode of treatment for alcohol and other drugs—number of service contacts

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Service contact

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item is a count of service contacts related to treatment that are recorded on a client record. Any client contact that does not constitute part of a treatment should not be considered a service contact. Contact with the client for administrative purposes, such as arranging an appointment, should not be included. This item is not collected for residential clients. Where multiple service provider staff have contact with the client at the same time, on the same occasion of service, the contact is counted only once. When multiple service contacts are recorded on the same day, each independent contact should be counted separately.
Collection methods:	To be collated at the close of a treatment episode.
Comments:	This metadata item provides a measure of the frequency of client contact and service utilisation within a treatment episode.

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Number of service contacts within a treatment episode for alcohol and other drug, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.6 KB)

Number of service events (non-admitted patient)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of non-admitted patient service events, total N[NNNNNN]
Synonymous names:	Non-admitted patient service event count
METeOR identifier:	270108
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of service events provided to non-admitted patients in the reference period, for each of the clinical service types in the hospital.
Data Element Concept:	Establishment—number of non-admitted patient service events

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Service event

Data element attributes

Collection and usage attributes

Guide for use:

Count of non-admitted patient service events for each of the clinical service types listed in the value domain of the metadata item Non-admitted patient service event—service event type (clinical), code N[N].

For each Non-admitted patient service event count, specify the

- Non-admitted patient service event—service event type (clinical), code N[N]
- Non-admitted patient service event—multi-disciplinary team status, code N
- Service contact—group session status, individual/group session indicator code ANN.N
- Non-admitted patient service event—patient present status, code N
- Non-admitted patient service event—service mode, hospital code N{N}

Comments:

Public patients are defined in accordance with the *1998-2003 Australian Health Care Agreements.*

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Non-admitted patient service event count, version

1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.49 KB)

Nursing diagnosis—other

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—nursing diagnosis (other), code (NANDA 1997-98) N.N[{.N}{.N}{.N}{.N}]
METeOR identifier:	270466
Registration status:	Health, Standard 01/03/2005
Definition:	The nursing diagnosis other than the principal nursing diagnosis, as represented by a code.
Data Element Concept:	Episode of care—nursing diagnosis

Value domain attributes

Representational attributes

Classification scheme:	North American Nursing Diagnosis Association (NANDA) Taxonomy 1997-1998
Representation class:	Code
Data type:	Number
Format:	N.N[{.N}{.N}{.N}{.N}]
Maximum character length:	6

Collection and usage attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	Up to seven nursing diagnoses may be nominated, according to the following: 1. Nursing diagnosis most related to the principal reason for admission (one only) 2-6. Other nursing diagnoses or relevance to the current episode.
Collection methods:	In considering how nursing diagnosis could be implemented, agencies may opt to introduce systems transparent to the clinician if there is confidence that a direct and reliable transfer to NANDA codes can be made from information already in place. Agencies implementing new information systems should consider the extent to which these can facilitate practice and at the same time lighten the burden of documentation. Direct incorporation of the codeset or automated mapping to it when the information is at a more detailed level are equally valid and

viable options.

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

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Relational attributes

Related metadata references: Supersedes Nursing diagnosis, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)

Nursing diagnosis—principal

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—nursing diagnosis (principal), code (NANDA 1997-98) N.N[{.N}{.N}{.N}{.N}]
METeOR identifier:	270220
Registration status:	Health, Standard 01/03/2005
Definition:	The principal nursing diagnosis, as represented by a code.
Data Element Concept:	Episode of care—nursing diagnosis

Value domain attributes

Representational attributes

Classification scheme:	North American Nursing Diagnosis Association (NANDA) Taxonomy 1997-1998
Representation class:	Code
Data type:	Number
Format:	N.N[{.N}{.N}{.N}{.N}]
Maximum character length:	6

Collection and usage attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	Up to seven nursing diagnoses may be nominated, according to the following: 1. Nursing diagnosis most related to the principal reason for admission (one only) 2-6. Other nursing diagnoses of relevance to the current episode.
Collection methods:	In considering how nursing diagnosis could be implemented, agencies may opt to introduce systems transparent to the clinician if there is confidence that a direct and reliable transfer to NANDA codes can be made from information already in place. Agencies implementing new information systems should consider the extent to which these can facilitate practice and at the same time lighten the burden of documentation. Direct incorporation of the code set or automated mapping to it when the information is at a more detailed level are equally valid and viable options.

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

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Relational attributes

Related metadata references: Supersedes Nursing diagnosis, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)

Nursing interventions

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Community nursing service episode—nursing intervention, code N
METeOR identifier:	270223
Registration status:	Health, Standard 01/03/2005
Definition:	The nursing action intended to relieve or alter a person's responses to actual or potential health problems, as represented by a code.
Data Element Concept:	Community nursing service episode—nursing intervention

Value domain attributes

Representational attributes

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

Permissible values:

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

Collection and usage attributes

Guide for use:

The following definitions are to assist in coding:

CODE 1 Coordination and collaboration of care

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

CODE 2 Supporting information carers

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

CODE 3 General nursing care

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

CODE 4 Technical nursing treatment or procedure

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

CODE 5 Counselling and emotional support

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

CODE 6 Teaching/education

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

CODE 7 Monitoring and surveillance

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

CODE 8 Formal case management

This code refers to the specific formal service, which is funded to provide case management for a person. Note that coordination and collaboration of care (Code 1) is not the same as formal case management.

CODE 9 Service needs assessment only

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

Data element attributes

Collection and usage attributes

Guide for use:

Up to eight codes may be selected. If Code 9 is selected no other nursing interventions are collected. If Code 9 is selected then code 07 in Community nursing service episode—goal of care, code NN must also be selected.

Collection methods:

Collect on continuing basis throughout the episode in the event of data collection that occurs prior to discharge. Up to eight codes may be collected. Within a computerised information system the detailed activities can be mapped to the Community Nursing Minimum Data Set Australia (CNMDSA) interventions enabling the option of a rich level of detail of activities or summarised information.

Comments:

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

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

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

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

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

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Origin:

Australian Council of Community Nursing Services 1997. Community Nursing Minimum Data Set Australia (CNMDSA), version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:

Supersedes Nursing interventions, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (24.24 KB)

Occasions of service (residential aged care services)—outreach/community

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (residential aged care service)—number of occasions of service (outreach/community), total N[NN]
METeOR identifier:	270308
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of occasions of service delivered by a residential aged care service employees to the patient in the home, place of work or other non-establishment site.
Data Element Concept:	Establishment (residential aged care service)—number of occasions of service

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Comments:	Required to adequately describe the services provided to non-admitted patients. Apart from acute hospitals, establishments generally provide a much more limited range of services for non-admitted patients and outreach/community patients/clients. Therefore disaggregation by type of episode is not as necessary as in acute hospitals.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Type of non-admitted patient care (residential aged care services), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.04 KB)

Occasions of service (residential aged care services)—outpatient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment (residential aged care service)—number of occasions of service (outpatient), total N[NN]
METeOR identifier:	270290
Registration status:	Health, Standard 01/03/2005
Definition:	The number of occasions of service delivered by residential aged care service employees. Outpatients are patients who receive non-admitted care. Non-admitted care is care provided to a patient who is not formally admitted but receives direct care from a designated clinic within the residential aged care service.
Data Element Concept:	Establishment (residential aged care service)—number of occasions of service

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN]
Maximum character length:	3
Unit of measure:	Occasion of service

Data element attributes

Collection and usage attributes

Comments:	Required to adequately describe the services provided to non-admitted patients. Apart from acute hospitals, establishments generally provide a much more limited range of services for non-admitted patients and outreach/community patients/clients. Therefore disaggregation by type of episode is not as necessary as in acute hospitals.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Type of non-admitted patient care (residential aged care services), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.04 KB)

Oestrogen receptor assay status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—oestrogen receptor assay results, code N
METeOR identifier:	291324
Registration status:	Health, Standard 13/06/2004
Definition:	The result of oestrogen receptor assay at the time of diagnosis of the primary breast tumour, as represented by a code.
Data Element Concept:	Person with cancer—oestrogen receptor assay results

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Test done, results positive (oestrogen receptor positive)
	2	Test done, results negative (oestrogen receptor negative)
Supplementary values:	0	Test not done (test not ordered or not performed)
	8	Test done but results unknown

Data element attributes

Collection and usage attributes

Comments:

Hormone receptor status is an important prognostic indicator for breast cancer.

The Australian Cancer Network Working Party established to develop guidelines for the pathology reporting of breast cancer recommends that hormone receptor assays be performed on all cases of invasive breast carcinoma. The report should include

- the percentage of nuclei staining positive and the predominant staining intensity (low, medium, high) and
- a conclusion as to whether the assay is positive or negative.

Source and reference attributes

Origin:

Royal College of Pathologists of Australasia

Australian Cancer Network

Commission on Cancer American College of Surgeons

Reference documents:

Royal College of Pathologists of Australasia Manual of Use and Interpretation of Pathology Tests: Third Edition Sydney (2001)

Australian Cancer Network Working Party The pathology reporting of breast cancer. A guide for pathologists, surgeons

and radiologists Second Edition Sydney (2001)

Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:	Supersedes Oestrogen receptor assay status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.8 KB)
Implementation in Data Set Specifications:	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Standard 07/12/2005

Onset of labour

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—labour onset type, code N
METeOR identifier:	269942
Registration status:	Health, Standard 01/03/2005
Definition:	The manner in which labour started in a birth event, as represented by a code.
Data Element Concept:	Birth event—labour onset type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Spontaneous
2	Induced
3	No labour

Supplementary values:

4	Not stated

Collection and usage attributes

Guide for use:

Labour commences at the onset of regular uterine contractions, which act to produce progressive cervical dilatation, and is distinct from spurious labour or pre-labour rupture of membranes.

If prostaglandins were given to induce labour and there is no resulting labour until after 24 hours, then code the onset of labour as spontaneous.

CODE 3 No labour
Can only be associated with a caesarean section.

Data element attributes

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Onset of labour, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.62 KB)
Implementation in Data Set Specifications:	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

Information specific to this data set:

How labour commenced is closely associated with method of birth and maternal and neonatal morbidity. Induction rates vary for maternal risk factors and obstetric complications and are important indicators of obstetric intervention.

Ophthalmological assessment—outcome (left retina)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—ophthalmological assessment outcome (left retina) (last 12 months), code N
METeOR identifier:	270472
Registration status:	Health, Standard 01/03/2005
Definition:	The result of an ophthalmological assessment for the left retina during the last 12 months, as represented by a code.
Data Element Concept:	Person—ophthalmological assessment outcome

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Normal
2	Diabetes abnormality
3	Non-diabetes abnormality
4	Not visualised

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

This is a repeating record of both eyes.

1st field - Right retina

2nd field - Left retina

Record the result of the fundus examination for each eye as: Normal/ Diabetes abnormality/ Non-diabetes abnormality/ or Not visualised.

Example:

- code 12 for right retina Normal and left retina Diabetes abnormality
- code 32 for right retina Non-diabetes abnormality and left retina Diabetes abnormality

Only the result of an assessment carried out in the last 12 months should be recorded.

Collection methods:

Ophthalmological assessment should be performed by an ophthalmologist or a suitably trained clinician.

A comprehensive ophthalmological examination includes:

- Checking visual acuity with Snellen chart - correct with pinhole if indicated;
- Examination for cataract;

- Examination of fundi with pupils dilated.

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: See also Person—ophthalmological assessment outcome (right retina) (last 12 months), code N Health, Standard 01/03/2005

Supersedes Ophthalmological assessment - outcome, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.48 KB)

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Superseded 21/09/2005

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

Information specific to this data set:

Patients with diabetes have increased risk of developing several eye complications including retinopathy, cataract and glaucoma that lead to loss of vision.

Many diabetes eye related problems are asymptomatic and require appropriate eye assessment to be detected. Regular eye checkup is important for patients suffering from diabetes mellitus. This helps to early detect abnormalities and to avoid or postpone complications and prevent blindness in people with diabetes.

According to Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus a comprehensive ophthalmological examination should be carried out:

- at diagnosis and then every 1-2 years for patients whose diabetes onset was at age 30 years or more,
- within five years of diagnosis and then every 1-2 years for patients whose diabetes onset was at age less than 30 years.

Assessment by an ophthalmologist is essential:

- at initial examination if the corrected visual acuity is less than 6/6 in either eye;
- at subsequent examinations if declining visual acuity is detected
- if any retinal abnormality is detected;
- if clear view of retina is not obtained.

References:

Vision Australia, No 2, 1997/8; University of Melbourne.

Diabetes Control and Complications Trial: DCCT New England Journal of Medicine, 329(14), September 30, 1993.

US National Eye Institute.

Ophthalmological assessment—outcome (right retina)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—ophthalmological assessment outcome (right retina) (last 12 months), code N
METeOR identifier:	270363
Registration status:	Health, Standard 01/03/2005
Definition:	The result of an ophthalmological assessment for the right retina during the last 12 months, as represented by a code.
Data Element Concept:	Person—ophthalmological assessment outcome

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Normal
2	Diabetes abnormality
3	Non-diabetes abnormality
4	Not visualised

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

This is a repeating record of both eyes.

1st field - Right retina

2nd field - Left retina

Record the result of the fundus examination for each eye as: Normal/ Diabetes abnormality/ Non-diabetes abnormality/ or Not visualised.

Example:

- code 12 for right retina Normal and left retina Diabetes abnormality
- code 32 for right retina Non-diabetes abnormality and left retina Diabetes abnormality

Only the result of an assessment carried out in the last 12 months should be recorded.

Collection methods:

Ophthalmological assessment should be performed by an ophthalmologist or a suitably trained clinician.

A comprehensive ophthalmological examination includes:

- Checking visual acuity with Snellen chart - correct with pinhole if indicated;
- Examination for cataract;

- Examination of fundi with pupils dilated.

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: See also Person—ophthalmological assessment outcome (left retina) (last 12 months), code N Health, Standard 01/03/2005

Supersedes Ophthalmological assessment - outcome, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.48 KB)

Implementation in Data Set Specifications: Diabetes (clinical) DSS Health, Superseded 21/09/2005

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

Information specific to this data set:

Patients with diabetes have increased risk of developing several eye complications including retinopathy, cataract and glaucoma that lead to loss of vision.

Many diabetes eye related problems are asymptomatic and require appropriate eye assessment to be detected. Regular eye checkup is important for patients suffering from diabetes mellitus. This helps to early detect abnormalities and to avoid or postpone complications and prevent blindness in people with diabetes.

According to Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus a comprehensive ophthalmological examination should be carried out:

- at diagnosis and then every 1-2 years for patients whose diabetes onset was at age 30 years or more,
- within five years of diagnosis and then every 1-2 years for patients whose diabetes onset was at age less than 30 years.

Assessment by an ophthalmologist is essential:

- at initial examination if the corrected visual acuity is less than 6/6 in either eye;
- at subsequent examinations if declining visual acuity is detected
- if any retinal abnormality is detected;
- if clear view of retina is not obtained.

References:

Vision Australia, No 2, 1997/8; University of Melbourne.

Diabetes Control and Complications Trial: DCCT New England Journal of Medicine, 329(14), September 30, 1993.

US National Eye Institute.

Ophthalmoscopy performed indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—ophthalmoscopy performed indicator (last 12 months), code N
METeOR identifier:	302821
Registration status:	Health, Standard 21/09/2005
Definition:	Whether or not an examination of the fundus of the eye by an ophthalmologist or optometrist, as a part of the ophthalmological assessment, has been undertaken in the last 12 months, as represented by a code.
Data Element Concept:	Person—ophthalmoscopy performed 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 fundus examination of eye has occurred. CODE 2 No: Record if a fundus examination of eye has not occurred.
Collection methods:	Ask the individual if he/she has undertaken an eye check, including examination of fundi with pupils dilated. Pupil dilatation and an adequate magnified view of the fundus is essential, using either detailed direct or indirect ophthalmoscopy or fundus camera. This will usually necessitate referral to an ophthalmologist.

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—ophthalmoscopy performed status (previous 12 months), 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:

Patients with diabetes have an increased risk of developing several eye complications including retinopathy, cataract and glaucoma that lead to loss of vision.

Eye examinations should be commenced at the time diabetes is diagnosed. If no retinopathy is present, repeat the eye examination at least every 2 years. Once retinopathy is identified more frequent observation is required.

Diabetic retinopathy is a leading cause of blindness. Retinopathy is characterised by proliferation of the retina's blood vessels, which may project into the vitreous, causing vitreous haemorrhage, proliferation of fibrous tissue and retinal detachment. It is often accompanied by microaneurysms and macular oedema, which can express as a blurred vision. The prevalence of retinopathy increases with increasing duration of diabetes. In the early stage, retinopathy is asymptomatic, however up to 20% of people with diabetes Type 2 have retinopathy at the time of diagnosis of diabetes. Cataract and glaucoma are also associated diabetic eye problems that could lead to blindness.

Regular eye checkups are important for patients suffering from diabetes mellitus. This helps to detect and treat abnormalities early and to avoid or postpone vision-threatening complications.

References:

Vision Australia, No. 2 - 1997/8; University of Melbourne.

Diabetes: complications: Therapeutic Guidelines Limited (05.04.2002).

Organisation end date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—organisation end date, DDMMYYYY
METeOR identifier:	288733
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The date on which an establishment, agency or organisation stopped or concluded operations or practice.
Data Element Concept:	Service provider organisation—organisation 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

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

Organisation expenses, total Australian currency

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Organisation—expenses, total Australian currency NNNNN.N
METeOR identifier:	359963
Registration status:	Health, Standard 05/12/2007
Definition:	Expenses of an organisation consisting mainly of wages, salaries and supplements, superannuation employer contributions, workers compensation premiums and payouts, purchases of goods and services and consumption of fixed capital (depreciation), in Australian currency.
Data Element Concept:	Organisation—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.

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
- Superannuation employer contributions
- Workers compensation premiums and payments
- Consumption of fixed capital (depreciation).
- Administrative expenses (excluding workers compensation premiums and payouts)
- Domestic services
- Drug supplies
- Food supplies
- Grants
- Medical and surgical supplies

- Patient transport
- Payments to visiting medical officers
- Repairs and maintenance
- Social benefits
- Subsidy expenses
- Other expenses

Collection methods:

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 formed using Organisation—purchase of goods and services, total Australian currency NNNNN.N Health, Standard 05/12/2007

Is formed using Organisation—employee related expenses, total Australian currency NNNNN.N Health, Standard 05/12/2007

Is formed using Organisation—depreciation 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

Organisation name

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (name)—organisation name, text [X(200)]
METeOR identifier:	288917
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The appellation by which an establishment, agency or organisation is known or called, as represented by text.
Data Element Concept:	Service provider organisation (name)—organisation name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(200)]
Maximum character length:	200

Data element attributes

Collection and usage attributes

Guide for use:	Generally, the complete establishment, agency or organisation name should be used to avoid any ambiguity in identification. This should usually be the same as company registration name. However, in certain circumstances (e.g. internal use), a short name (i.e. an abbreviated name by which the organisation is known) or a locally used name (e.g. where a medical practice is known by a name that is different to the company registration name) can be used. Further, a business unit within an organisation may have its own separate identity; this should be captured (as the unit name – see Organisation name type). More than one name can be recorded for an organisation. That is, this field is a multiple occurring field. At least one organisation name must be recorded for each organisation and each name must have an appropriate Organisation name type.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

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

Organisation revenues

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Organisation—revenue, total Australian currency NNNNN.N
METeOR identifier:	357510
Registration status:	Health, Standard 05/12/2007
Definition:	Revenues of an organisation relating to **patient fees**, **recoveries**, and **other revenue** in Australian currency.
Data Element Concept:	Organisation—revenue

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:

Revenues are to be reported in millions to the nearest 100,000 e.g. $4,064,000 should be reported as $4.1 million.

Revenue arises from:

- the sale of goods,
- the rendering of services, and
- the use by others of entity assets yielding interest, royalties and dividends.

Goods includes goods produced by the entity for the purpose of sale and goods purchased for resale, such as merchandise purchased by a retailer or land and other property held for resale.

The rendering of services typically involves the performance by the entity of a contractually agreed task over an agreed period of time. The services may be rendered within a single period or over more than one period. Some contracts for the rendering of services are directly related to construction contracts, for example, those for the services of project managers and architects. Revenue arising from these contracts is not dealt with in this Standard but is dealt with in accordance with the requirements for construction contracts as specified in AASB 111 Construction Contracts.

The use by others of entity assets gives rise to revenue in the form of:

(a) interest – charges for the use of cash or cash equivalents or

amounts due to the entity;

(b) royalties – charges for the use of long-term assets of the entity, for example, patents, trademarks, copyrights and computer software; and

(c) dividends – distributions of profits to holders of equity investments in proportion to their holdings of a particular class of capital.

Revenue is the gross inflow of economic benefits during the period arising in the course of the ordinary activities of an entity when those inflows result in increases in equity, other than increases relating to contributions from equity participants.

Revenue includes only the gross inflows of economic benefits received and receivable by the entity on its own account.

Amounts collected on behalf of third parties such as sales taxes, goods and services taxes and value added taxes are not economic benefits which flow to the entity and do not result in increases in equity. Therefore, they are excluded from revenue. Similarly, in an agency relationship, the gross inflows of economic benefits include amounts collected on behalf of the principal and which do not result in increases in equity for the entity. The amounts collected on behalf of the principal are not revenue. Instead, revenue is the amount of commission.

Collection methods:

Revenues are to be reported for the *Source of public and private revenue* and *Health industry relevant provider type* data elements.

Source of public and private revenue

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

Codes 101–103; 204; 207; 301

Health industry relevant provider type

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

Codes 106–109; 111; 115–119; 123; 201 and 203

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Reference documents:

ABS 2003. Australian System of Government Finance Statistics: Concepts, Sources and Methods (Cat. no. 5514.0.55.001) 10/10/2003.

Australian Accounting Standards Board 118, July 2007, <www.aasb.com.au>.

Relational attributes

Implementation in Data Set Specifications:

Government health expenditure function revenue data cluster Health, Standard 05/12/2007

Government health expenditure organisation revenue data element cluster Health, Standard 05/12/2007

Organisation start date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—organisation start date, DDMMYYYY
METeOR identifier:	288963
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The date on which an establishment, agency or organisation started or commenced operations or service.
Data Element Concept:	Service provider organisation—organisation start 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 field must—

- be a valid date;
- be less than or equal to the Organisation end date.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

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:

If the date is estimated in some way, it is recommended that the metadata item *Date accuracy indicator* also be recorded at the time of record creation to flag the accuracy of the data.

For data exchange and /or manipulation of data from diverse sources the *Date accuracy indicator* metadata item must be used in conjunction with the *Organisation start date* in all instances to ensure data integrity and accuracy of analysis.

Other drug of concern

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—drug of concern (other), code (ASCDC 2000 extended) NNNN
METeOR identifier:	270110
Registration status:	Health, Standard 01/03/2005
Definition:	A drug apart from the principal drug of concern which the client states as being a concern, as represented by a code.
Data Element Concept:	Episode of treatment for alcohol and other drugs—drug of concern

Value domain attributes

Representational attributes

Classification scheme:	Australian Standard Classification of Drugs of Concern 2000
Representation class:	Code
Data type:	String
Format:	NNNN
Maximum character length:	4

Supplementary values:

Value	Meaning
0005	Opioid analgesics not further defined
0006	Psychostimulants not further defined

Collection and usage attributes

Guide for use:

The Australian Standard Classification of Drugs of Concern (ASCDC) provides a number of supplementary codes that have specific uses and these are detailed within the ASCDC e.g. 0000 = inadequately described.

Other supplementary codes that are not already specified in the ASCDC may be used in National Minimum Data Sets (NMDS) when required. In the Alcohol and other drug treatment service NMDS, two additional supplementary codes have been created which enable a finer level of detail to be captured:

CODE 0005 Opioid analgesics not further defined

This code is to be used when it is known that the client's principal drug of concern is an opioid but the specific opioid used is not known. The existing code 1000 combines opioid analgesics and non-opioid analgesics together into Analgesics nfd and the finer level of detail, although known, is lost.

CODE 0006 Psychostimulants not further defined

This code is to be used when it is known that the client's principal drug of concern is a psychostimulant but not which type. The existing code 3000 combines stimulants and hallucinogens together into Stimulants and hallucinogens nfd and the finer level of detail, although known, is lost.

Psychostimulants refer to the types of drugs that would normally be coded to 3100-3199, 3300-3399 and 3400-3499 categories plus 3903 and 3905.

Data element attributes

Collection and usage attributes

Guide for use:

Record each additional drug of concern (according to the client) relevant to the treatment episode. The other drug of concern does not need to be linked to a specific treatment type.

More than one drug may be selected. There should be no duplication with the principal drug of concern.

Collection methods:

Any other drug of concern for the client should be recorded upon commencement of a treatment episode.

For clients whose treatment episode is related to the alcohol and other drug use of another person, this metadata item should not be collected.

Comments:

This item complements principal drug of concern. The existence of other drugs of concern may have a role in determining the types of treatment required and may also influence treatment outcomes.

Source and reference attributes

Submitting organisation:

Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references:

Supersedes Other drug of concern, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.41 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

Other treatment type 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 type (other), code [N]
METeOR identifier:	270076
Registration status:	Health, Standard 01/03/2005
Definition:	All other forms of treatment provided to the client in addition to the main treatment type for alcohol and other drugs, as represented by a code.
Data Element Concept:	Episode of treatment for alcohol and other drugs—treatment type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Withdrawal management (detoxification)
2	Counselling
3	Rehabilitation
4	Pharmacotherapy
5	Other

Collection and usage attributes

Guide for use:

CODE 1 Withdrawal management (detoxification)

Refers to any form of withdrawal management, including medicated and non-medicated.

CODE 2 Counselling

Refers to any method of individual or group counselling directed towards identified problems with alcohol and/or other drug use or dependency. This selection excludes counselling activity that is part of a rehabilitation program as defined in Code 3.

CODE 3 Rehabilitation

Refers to an intensive treatment program that integrates a range of services and therapeutic activities that may include counselling, behavioural treatment approaches, recreational activities, social and community living skills, group work and relapse prevention. Rehabilitation treatment can provide a high level of support (i.e. up to 24 hours a day) and tends towards a medium to longer-term duration. Rehabilitation activities can occur in residential or non-residential settings. Counselling that is included within an overall rehabilitation program should be coded to Code 3 for Rehabilitation, not to Code 2 as a separate treatment episode for counselling.

CODE 4 Pharmacotherapy

Refers to pharmacotherapies that include those used as maintenance therapies (e.g. naltrexone, buprenorphine, and methadone treatment) and those used as relapse prevention. Use Code 1 (withdrawal management) where a pharmacotherapy is used solely for withdrawal. Note collection exclusions: excludes clients who are on an opioid pharmacotherapy maintenance program and are not receiving any other form of treatment.

Data element attributes

Collection and usage attributes

Guide for use:

To be completed at cessation of treatment episode.

Only report treatment recorded in the client's file that is in addition to, and not a component of, the main treatment type for alcohol and other drugs. Treatment activity reported here is not necessarily for principal drug of concern in that it may be treatment for other drugs of concern.

More than one code may be selected.

Collection methods:

This field should be left blank if there are no other treatment types for the episode.

Comments:

Information about treatment provided is of fundamental importance to service delivery and planning.

Source and reference attributes

Submitting organisation:

Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references:

Supersedes Other treatment type for alcohol and other drugs, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.72 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

Outcome of initial treatment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Cancer treatment—outcome of treatment, code N.N
METeOR identifier:	289304
Registration status:	Health, Standard 04/06/2004
Definition:	The response of the tumour at the completion of the initial treatment modalities, as represented by a code.
Data Element Concept:	Cancer treatment—outcome of treatment

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N.N
Maximum character length:	2

Permissible values:

Value	Meaning
1.0	Complete response
2.1	Partial response
2.2	Stable or static disease
2.3	Progressive disease
2.9	Incomplete response

Supplementary values:

9.0	Not assessed or unable to be assessed

Collection and usage attributes

Guide for use:

CODE 1.0 Complete response

Complete disappearance of all measurable disease, including tumour markers, for at least four weeks. No new lesions or new evidence of disease.

CODE 2.1 Partial response

A decrease by at least 50% of the sum of the products of the maximum diameter and perpendicular diameter of all measurable lesions, for at least four weeks. No new lesions or worsening of disease.

CODE 2.2 Stable or static disease

No change in measurable lesions qualifying as partial response or progression and no evidence of new lesions.

CODE 2.3 Progressive disease

An increase by at least 25% of the sum of the products of the maximum diameter and a perpendicular diameter of any measurable lesion, or the appearance of new lesions.

Data element attributes

Source and reference attributes

Origin:	New South Wales Health Department

Reference documents: Public Health Division NSW Clinical Cancer Data Collection for Outcomes and Quality. Data Dictionary Version 1 Sydney NSW Health Dept (2001)

Relational attributes

Related metadata references: Supersedes Outcome of initial treatment, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.79 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 item is collected for assessing disease status at the end of primary treatment.

Outcome of last previous pregnancy

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Pregnancy (last previous)—pregnancy outcome, code N
METeOR identifier:	270006
Registration status:	Health, Standard 01/03/2005
Definition:	Outcome of the most recent pregnancy preceding this pregnancy, as represented by a code.
Data Element Concept:	Pregnancy (last previous)—pregnancy outcome

Value domain attributes

Representational attributes

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

Permissible values:

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

Data element attributes

Collection and usage attributes

Guide for use:	In the case of multiple pregnancy with fetal loss before 20 weeks, code on outcome of surviving fetus(es) beyond 20 weeks.
Comments:	This data item is recommended by the World Health Organization. It is collected in some states and territories. Adverse outcome in previous pregnancy is an important risk factor for subsequent pregnancy.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Outcome of last previous pregnancy, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.67 KB)

Outpatient clinic type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—outpatient clinic type, code N[N]
METeOR identifier:	336952
Registration status:	Health, Standard 04/07/2007
Definition:	The organisational unit or organisational arrangement through which a hospital provides healthcare services in an outpatient setting, as represented by a code.
Data Element Concept:	Establishment—outpatient clinic type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	Allied Health
2	Dental
3	Gynaecology
4	Obstetrics
5	Cardiology
6	Endocrinology
7	Oncology
8	Respiratory
9	Gastroenterology
10	Medical
11	General practice/primary care
12	Paediatric medical
13	Endoscopy
14	Plastic surgery
15	Urology
16	Orthopaedic surgery
17	Ophthalmology
18	Ear, nose and throat
19	Pre-admission and pre-anaesthesia
20	Chemotherapy
21	Dialysis
22	Surgery
23	Paediatric surgery
24	Renal medical

Collection and usage attributes

Guide for use:

The rules for allocating (mapping) clinic services to the clinic codes structure is the responsibility of each State and Territory and these rules need to be applied consistently within each State and Territory.

In most cases, reference to the code guide of permissible values will be adequate to map a hospital's clinics to the data domain. If not, general principles for mapping existing clinics to the data domain should take account of (a) the nature of the specialty, (b) patient characteristics, e.g. age, and (c) the field of practice of the service provider.

Where the patient characteristics have determined that a paediatric clinic type is appropriate, then further differentiation between surgical and medical is determined by (a) the nature of the specialty, and (b) the field of practice of the service provider. That is, paediatric medical would include any investigations, treatment(s) or services provided to a child which do not pertain to the surgical care of diseases or injuries.

In paediatric hospitals, the full range of clinic types should be used.

A guide for the permissible values of codes for the outpatient clinic types is as follows:

CODE 1 Allied Health

- Audiology.
- Clinical Pharmacology.
- Neuropsychology.
- Dietetics.
- Occupational therapy.
- Optometry.
- Orthoptics.
- Orthotics.
- Physiotherapy.
- Podiatry.
- Prosthetics.
- Psychology.
- Social work.
- Speech pathology.

Includes clinics specified in mapping list above run solely by these Allied Health (AH) professionals. Example: A speech Pathologist conducting a clinic with booked patients for speech pathology services.

Excludes services provided by AH professionals in clinics classified in codes 2-23. Example: a physiotherapist running a cardiac rehabilitation clinic is classified to the Cardiology Clinic (see code 5).

CODE 2 Dental

- Dental.

CODE 3 Gynaecology

- Gynaecology.
- Gynaecological oncology (excluding chemotherapy).
- Menopause.
- Assisted reproduction, infertility.

- Family planning.

CODE 4 Obstetrics

- Obstetrics.
- Childbirth education.
- Antenatal.
- Postnatal.

Excludes gestational diabetes (see code 6).

CODE 5 Cardiology

- Cardiac rehabilitation.
- ECG.
- Doppler.
- Cardiac stress test.
- Hypertension.
- Pacemaker.

Excludes cardiac catheterisation (see code 22).

CODE 6 Endocrinology

- Endocrine.
- Gestational diabetes.
- Thyroid.
- Metabolic.
- Diabetes.
- Diabetes education.

CODE 7 Oncology

- Oncology.
- Lymphoedema.
- Radiation oncology.

Excludes chemotherapy (see code 20).

Excludes gynaecological oncology (see code 3).

CODE 8 Respiratory

- Asthma.
- Asthma education.
- Respiratory; excludes tuberculosis (see code 10).
- Cystic Fibrosis.
- Sleep.
- Pulmonary.

CODE 9 Gastroenterology

- Gastroenterology.

Excludes endoscopy (see code 13).

CODE 10 Medical

- Aged care, geriatric, gerontology.
- Allergy.
- Anti-coagulant.
- Clinical Measurement; include with relevant specialty clinic type where clinical measurement services are specific to a specialty (see codes 1-23) e.g. urodynamic analysis is counted with Urology (see code 15).
- Dementia.
- Dermatology.
- Development disability.

- Epilepsy.
- Falls.
- General medicine.
- Genetic.
- Haematology, haemophilia.
- Hepatobiliary.
- Hyperbaric medicine.
- Immunology, HIV.
- Infectious diseases; Communicable diseases; Hep B, C; includes tuberculosis.
- Men's Health.
- Metabolic bone.
- Excludes Nephrology (see code 24); excludes renal (see code 24); excludes dialysis (see code 21).
- Neurology, neurophysiology.
- Occupational medicine.
- Other.
- Pain management
- Palliative.
- Refugee clinic.
- Rehabilitation; excludes cardiac rehabilitation (see code 5).
- Rheumatology.
- Sexual Health.
- Spinal.
- Stoma therapy.
- Transplants (excludes kidney transplants see code 24).
- Wound, Dressing clinic.

CODE 11 General practice/primary care

- General Practice, Primary Care.

Excludes Medicare billable patients; defined specialty general practice clinics only.

CODE 12 Paediatric Medical

- Adolescent health.
- Neonatology.
- Paediatric medicine.

In paediatric hospitals the full range of service types should be used. That is, paediatric medical should be reported as medical and paediatric surgery should be reported as surgery.

CODE 13 Endoscopy

Includes all occasions of service for endoscopy including cystoscopy, gastroscopy, oesophagoscopy, duodenoscopy, colonoscopy, bronchoscopy, laryngoscopy, sigmoidoscopy.

Care must be taken to ensure procedures for admitted patients are excluded from this category.

CODE 14 Plastic surgery

- Craniofacial.
- Melanoma.
- Plastic surgery.

CODE 15 Urology

- Urology.

Includes urodynamic measurement and IVPs.

CODE 16 Orthopaedic surgery

- Fracture.
- Hand.
- Orthopaedics Surgery.
- Other.
- Scoliosis.
- Neck of femur.

CODE 17 Ophthalmology

- Ophthalmology.
- Cataract extraction.
- Lens insertion.

CODE 18 Ear, nose and throat

- Ear, nose and throat.
- Otitis media.
- Oral.

CODE 19 Pre-admission and pre-anaesthesia

- Pre-admission.
- Pre-anaesthesia.

CODE 20 Chemotherapy

Includes all forms of chemotherapy.

CODE 21 Dialysis

Dialysis and includes renal dialysis education. See code 24 for Renal medicine

CODE 22 Surgery

- Cardiac.
- Vascular.
- Cardiac catheterisation.
- Colorectal.
- Upper GI surgery.
- General surgery.
- Neurosurgery.
- Other surgery.
- Thoracic surgery.

CODE 23 Paediatric surgery

In paediatric hospitals the full range of service types should be used. That is, paediatric medical should be reported as medical and paediatric surgery should be reported as surgery.

CODE 24 Renal Medical

- Renal Medicine.
- Nephrology.
- Includes pre and post transplant treatment, support and education.
- Excludes dialysis and renal dialysis education. See code 21

Source and reference attributes

Origin: National Centre for Classification in Health consultant's report to Outpatients National Minimum Data Set Development Working Group, September 2004.

Data element attributes

Collection and usage attributes

Guide for use: Does not include services provided through community health settings (such as community and child health centres).

Source and reference attributes

Submitting organisation: Non-admitted patient NMDS Development Working Group, 2006

Relational attributes

Related metadata references: See also Establishment—number of occasions of service, total N[NNNNNN] Health, Standard 04/07/2007

Supersedes Establishment—outpatient clinic type, code N[N] Health, Superseded 04/07/2007

Implementation in Data Set Specifications: Outpatient care NMDS Health, Standard 04/07/2007

Implementation start date: 01/07/2007

Overdue patient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—overdue patient status, code N
METeOR identifier:	270009
Registration status:	Health, Standard 01/03/2005
Definition:	Whether or not a patient is an overdue patient, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode—overdue patient status

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Overdue patient
2	Other

Data element attributes

Collection and usage attributes

Guide for use:

This metadata item is only required for patients in Elective surgery waiting list episode—clinical urgency, code N categories with specified maximum desirable waiting times. Overdue patients are those for whom the hospital system has failed to provide timely care and whose wait may have an adverse effect on the outcome of their care. They are identified by a comparison of Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] or Elective surgery waiting list episode —waiting time (at a census date), total days N[NNN] and the maximum desirable time limit for the Elective surgery waiting list episode—clinical urgency, code N classification.

A patient is classified as overdue if ready for care and waiting time at admission or waiting time at a census date is longer than 30 days for patients in Elective surgery waiting list episode—clinical urgency, code N category 1 or 90 days for patients in Elective surgery waiting list episode—clinical urgency, code N category 2.

Comments:

This metadata item is not used for patients in Elective surgery waiting list episode—clinical urgency, code N category 3 as there is no specified timeframe within which it is desirable that they are admitted. The metadata item Elective surgery waiting list episode—extended wait patient indicator, status code N identifies patients in Elective surgery waiting list episode—

clinical urgency, code N category 3 who have waited longer than one year at admission or at the time of a census.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

See also Elective surgery waiting list episode—clinical urgency, code N Health, Standard 01/03/2005

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

Supersedes Overdue patient, version 3, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.39 KB)

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

Palliative care agency service delivery setting

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—service delivery setting, palliative care agency code N
METeOR identifier:	297661
Registration status:	Health, Standard 05/12/2007
Definition:	The setting in which a **palliative care agency** delivers palliative care services, as represented by a code.
Data Element Concept:	Service provider organisation—service delivery setting

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Private residence
2	Residential - aged care setting
3	Residential - other setting
4	Non-residential setting
5	Inpatient - designated palliative care unit or hospice
6	Inpatient - other than a designated palliative care unit
7	Outpatient - in a hospital/hospice

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Private residence

This may include a caravan, a mobile home, a houseboat or a unit in a retirement village.

CODE 2 Residential - aged care setting

Includes high and low care residential aged care facilities. Does not include units in a retirement village.

CODE 3 Residential - other setting

Includes a residential facility other than an aged care facility; a prison; or a community living environment including a group home. This code does not include inpatient settings e.g. hospitals and hospices.

CODE 4 Non-residential setting

Includes day respite centres and day centres. It does not include hospital outpatient departments.

CODE 5 Inpatient - designated palliative care unit or hospice

A dedicated ward or unit that receives identified funding for palliative care and/or primarily delivers palliative care. The unit may be a standalone unit (i.e. a hospice).

CODE 6 Inpatient - other than designated palliative care unit

Includes all beds not in a unit designated for palliative care. These are usually located in acute hospital wards. Excludes designated palliative care units.

CODE 7 Outpatient - in a hospital/hospice

Includes palliative care services provided at a hospital/hospice in an outpatient setting. Excludes all inpatient settings.

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

Parity

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—parity, total N[N]
METeOR identifier:	302013
Registration status:	Health, Standard 29/11/2006
Definition:	The total number of previous pregnancies experienced by the woman that have resulted in a live birth or a stillbirth.
Data Element Concept:	Female—parity

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	String	
Format:	N[N]	
Maximum character length:	2	
Supplementary values:	Value	Meaning
	99	Not stated
Unit of measure:	Pregnancy	

Data element attributes

Collection and usage attributes

Guide for use:

This is to be recorded for each pregnancy.

This data element includes live births and stillbirths of 20 weeks gestation or 400 grams birthweight.

This data element excludes:

- the current pregnancy;
- pregnancies resulting in spontaneous or induced abortions before 20 weeks gestation; and
- ectopic pregnancies.

A primigravida (a woman pregnant for the first time) has a parity of 0.

Collection methods:

A pregnancy with multiple fetuses is counted as one pregnancy.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Partner organisation type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation—partner organisation type, palliative care code N[N]
METeOR identifier:	290715
Registration status:	Health, Standard 05/12/2007
Definition:	The type of organisation with which a palliative care service provider organisation has formal working partnership(s) in place, as represented by a code.
Data Element Concept:	Service provider organisation—partner organisation type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	Palliative care services
2	Hospitals
3	Community nursing agencies
4	Residential aged care facilities
5	Allied health services
6	Aboriginal health services
7	Medical practices
8	Integrated health centres
9	Universities/research centres
10	Volunteer support services
99	Other

Data element attributes

Collection and usage attributes

Guide for use:

A formal working partnership involves arrangements between a service provider organisation and other service providers and organisations, aimed at providing integrated and seamless care, so that clients are able to move smoothly between services and service settings.

A formal working partnership is a verbal or written agreement between two or more parties. It specifies the roles and responsibilities of each party, including the expected outcomes of the agreement.

Key elements of a formal working partnership are that it is organised, routine, collaborative, and systematic. It excludes ad hoc arrangements. Examples of formal working partnerships

include the existence of: written service agreements; formal liaison; referral and discharge planning processes; formal and routine consultation; protocols; partnership working groups; memoranda of understanding with other providers; and case conferencing.

Where partnerships exist for case conferencing purposes, record all partners involved.

CODE 1 Palliative care services

Includes services whose substantive work is with patients who have a life-limiting illness. These palliative care services may provide services in the community and/or in admitted patient settings (including hospices).

CODE 2 Hospitals

Includes emergency departments. Excludes hospices/designated palliative care units in a hospital, and other palliative care agencies as defined under Code 1. Also excludes hospital-based allied health services and individual medical practitioners.

CODE 7 Medical practices

Includes practices of general practitioners and individual specialist physicians such as specialists in palliative care, oncologists, urologists and neurologists.

CODE 8 Integrated health centres

Includes multipurpose centres, aged care centres and specialist care centres such as cancer centres.

CODE 9 Universities/research centres

Includes universities that may undertake research and development projects.

CODE 99 Other

Includes organisations based in the community such as schools, clubs, workplaces, organisations that provide respite care or pastoral care and 'Meals on wheels'.

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 – working partnerships indicator, yes/no code N* is 'yes' (code 1).

Patient days

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of patient days, total N[N(7)]
METeOR identifier:	270045
Registration status:	Health, Standard 01/03/2005
Definition:	The total number of days for all patients who were admitted for an episode of care and who separated during a specified reference period.
Data Element Concept:	Establishment—number of patient days

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N(7)]
Maximum character length:	8
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:

A day is measured from midnight to 2359 hours.

The following basic rules are used to calculate the number of patient days for **overnight stay patients**:

- The day the patient is admitted is a patient day
- If the patient remains in hospital from midnight to 2359 hours count as a patient day
- The day a patient goes on leave is counted as a leave day
- If the patient is on leave from midnight to 2359 hours count as a leave day
- The day the patient returns from leave is counted as a patient day
- The day the patient is separated is not counted as a patient day.

The following additional rules cover special circumstances and in such cases, override the basic rules:

- Patients admitted and separated on the same date (**same-day patients**) are to be given a count of one patient day
- If the patient is admitted and goes on leave on the same day, count as a patient day
- If the patient returns from leave and goes on leave on the same date, count as a leave day.
- If the patient returns from leave and is separated, it is not counted as either a patient day or a leave day.
- If a patient goes on leave the day they are admitted and does not return from leave until the day they are

discharged, count as one patient day (the day of admission is counted as a patient day, the day of separation is not counted as a patient day).

When calculating total patient days for a specified period:

- Count the total patient days of those patients separated during the specified period including those admitted before the specified period
- Do not count the patient days of those patients admitted during the specified period who did not separate until the following reference period
- Contract patient days are included in the count of total patient days. If it is a requirement to distinguish contract patient days from other patient days, they can be calculated by using the rules contained in the data element: total contract patient days.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Is formed using Episode of admitted patient care (newborn) – number of qualified days, total N[NNNN] Health, Standard 01/03/2005

Supersedes Patient days, version 3, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.19 KB)

Patient listing status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—patient listing status, readiness for care code N
METeOR identifier:	269996
Registration status:	Health, Standard 01/03/2005
Definition:	An indicator of the person's readiness to begin the process leading directly to being admitted to hospital for the awaited procedure, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode—patient listing status

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Ready for care
2	Not ready for care

Data element attributes

Collection and usage attributes

Guide for use:

A patient may be 'ready for care' or 'not ready for care'. Ready for care patients are those who are prepared to be admitted to hospital or to begin the process leading directly to admission. These could include investigations/procedures done on an outpatient basis, such as autologous blood collection, pre-operative diagnostic imaging or blood tests. Not ready for care patients are those who are not in a position to be admitted to hospital. These patients are either:

- staged patients whose medical condition will not require or be amenable to surgery until some future date; for example, a patient who has had internal fixation of a fractured bone and who will require removal of the fixation device after a suitable time; or
- deferred patients who for personal reasons are not yet prepared to be admitted to hospital; for example, patients with work or other commitments which preclude their being admitted to hospital for a time.

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

Staged and deferred patients should not be confused with patients whose operation is postponed for reasons other than their own unavailability; for example, surgeon unavailable,

operating theatre time unavailable owing to emergency workload. These patients are still 'ready for care'.

Periods when patients are not ready for care should be excluded in determining 'Waiting time (at removal)' and 'Waiting time (at a census date)'.

Comments:

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

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

Source and reference attributes

Submitting organisation:

Hospital Access Program Waiting Lists Working Group

Waiting Times Working Group

Origin:

National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Patient listing status, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.69 KB)

Is used in the formation of Elective surgery waiting list episode—waiting time (at a census date), total days N[NNN] Health, Standard 01/03/2005

Patient present status (non-admitted patient)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient service event—patient present status, code N
METeOR identifier:	270081
Registration status:	Health, Standard 01/03/2005
Definition:	The presence or absence of a patient at a service event, as represented by a code.
Data Element Concept:	Non-admitted patient service event—patient present status

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Patient present with or without carer(s)/relative(s)
2	Carer(s)/relative(s) of the patient only

Data element attributes

Collection and usage attributes

Guide for use: A service event is regarded as having occurred when a consultation occurs between their carer/relative and a service provider at an appointment when the patient is not present, provided that the carer/relative is not a patient in their own right for the service contact. Where both are patients, it is considered that service events have been provided for the person(s) in whose medical record the service event is noted.

Relational attributes

Related metadata references: Supersedes Non-admitted patient service event - patient present status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.36 KB)

Patients in residence at year end

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—patients/clients in residence at year end, total N[NNN]
METeOR identifier:	270046
Registration status:	Health, Standard 01/03/2005
Definition:	A headcount of all formally admitted patients/clients in residence in long-stay facilities.
Data Element Concept:	Establishment—patients/clients in residence at year end

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Collection methods:	For public psychiatric hospitals and alcohol and drug hospitals, all states have either an annual census or admission tracking that would enable a statistical census. The Commonwealth Department of Health and Ageing is able to carry out a statistical census from its residential aged care service databases. A headcount snapshot could be achieved either by census or by the admission/discharge derivation approach. There are difficulties with the snapshot in view of both seasonal and day of the week fluctuations. Most of the traffic occurs in a small number of beds. Any headcount should avoid the problems associated with using 31 December or 1 January. The end of the normal financial year is probably more sensible (the Wednesday before the end of the financial year was suggested, but probably not necessary). This should be qualified by indicating that the data does not form a time series in its own right.
Comments:	The number of separations and bed days for individual long-stay establishments is often a poor indication of the services provided. This is because of the relatively small number of separations in a given institution. Experience has shown that the number of patients/clients in residence can often give a more reliable picture of the levels of services being provided.

Source and reference attributes

Submitting organisation:	Morbidity working party

Relational attributes

Related metadata references:	Supersedes Patients in residence at year end, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.89 KB)

Perineal status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female (mother)—postpartum perineal status, code N
METeOR identifier:	269939
Registration status:	Health, Standard 01/03/2005
Definition:	The state of the perineum following birth, as represented by a code.
Context:	Perinatal
Data Element Concept:	Female (mother)—postpartum perineal status

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Intact
2	1st degree laceration/vaginal graze
3	2nd degree laceration
4	3rd degree laceration
5	Episiotomy
6	Combined laceration and episiotomy
7	4th degree laceration
8	Other

Supplementary values:

9	Not stated

Collection and usage attributes

Guide for use:	Vaginal tear is included in the same group as 1st degree laceration to be consistent with ICD-10-AM code. Other degrees of laceration are as defined in ICD-10-AM.
Comments:	While 4th degree laceration is more severe than an episiotomy it has not been placed in order of clinical significance within the data domain. Instead it has been added to the data domain as a new code rather than modifying the existing order of data domain code values. This is because information gatherers are accustomed to the existing order of the codes. Modifying the existing order may result in miscoding of data. This approach is consistent with established practice in classifications wherein a new data domain identifier (or code number) is assigned to any new value meaning that occurs, rather than assigning this new value domain meaning to an existing data domain identifier.

Data element attributes

Collection and usage attributes

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

Relational attributes

Related metadata references: Supersedes Perineal status, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.78 KB)

Period of residence in Australia

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—period of residence in Australia, years code NN
METeOR identifier:	270050
Registration status:	Health, Standard 01/03/2005
Definition:	Length of time in years a person has lived in Australia.
Data Element Concept:	Person—period of residence in Australia

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
00	Under one year residence in Australia
01-97	1 to 97 years residence in Australia
98	Born in Australia

Supplementary values:

99	Unknown

Data element attributes

Collection and usage attributes

Collection methods:

This information may be obtained either from:

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

Comments:

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

This item was not considered a high priority by the Office of Multicultural Affairs (1988) and to date only the country of birth and Indigenous status are considered by the National Health Data Committee to be justified for inclusion in the National Minimum Data Set - Admitted patient care.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Period of residence in Australia, version 1, DE,

NHDD, NHIMG, Superseded 01/03/2005.pdf (14.6 KB)

Peripheral neuropathy (status)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—peripheral neuropathy indicator, code N
METeOR identifier:	302457
Registration status:	Health, Standard 21/09/2005
Definition:	Whether peripheral neuropathy is present, as represented by a code.
Data Element Concept:	Person—peripheral neuropathy 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 peripheral neuropathy is present in the person. CODE 2 No: Record if peripheral neuropathy is not present in the person. Record whether or not peripheral neuropathy is present determined by clinical judgement following assessment using pinprick and vibration (using perhaps a Biothesiometer) or Monofilament.
Collection methods:	Examine for neuropathy by testing reflexes and sensation preferably using tuning fork (standard vibration fork 128 hz), pinprick, 10g monofilament and/or biothesiometer. The preferred assessment methods are monofilament and biothesiometer. These two non-invasive tests provide more objective and repeatable results than testing sensation with pinprick or a tuning fork, which are very difficult to standardise. 1 The 'Touch-Test' Sensory Evaluation (Semmens-Weinstein Monofilaments) application guidelines: • Occlude the patient's vision by using a shield or by having

the patient look away or close his or her eyes.

- Instruct the patient to respond when a stimulus is felt by saying 'touch' or 'yes'.
- Prepare to administer the stimulus to the foot (dorsal or plantar surface).
- Press the filament of the Touch
- Test at a 90 degree angle against the skin until it bows. Hold in place for approximately 1.5 seconds and then remove.

To assure the validity of the sensory test findings:

- The patient must not be able to view the administration of the stimuli so that false indications are avoided.
- The nylon filament must be applied at a 90 degree angle against the skin until it bows for approximately 1.5 second before removing.
- If the patient does not feel the filament, then protective pain sensation has been lost.

2 Testing vibration sensation with a biothesiometer - application guidelines:

- The biothesiometer has readings from 0 to 50 volts. It can be made to vibrate at increasing intensity by turning a dial.
- A probe is applied to part of the foot, usually on the big toe.
- The person being tested indicates as soon as he/she can feel the vibration and the reading on the dial at that point is recorded.

The reading is low in young normal individuals (i.e. they are very sensitive to vibration). In older individuals, the biothesiometer reading becomes progressively higher. From experience, it is known that the risk of developing a neuropathic ulcer is much higher if a person has a biothesiometer reading greater than 30-40 volts.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Reference documents:

1997 North Coast Medical, INC. San Jose, CA 95125; 800 821 - 9319

Duffy MD, John C and Patout MD, Charles A. 1990. 'Management of the Insensitive Foot in Diabetes: Lessons from Hansen's Disease'. Military Medicine, 155:575-579

Bell- Krotovski OTR, FAOT, FAOTA, Judith and Elizabeth Tomancik LOTR. 1987.The Repeatability of testing with Semmens-Weinstein Monofilaments. 'The Journal of Hand Surgery,' 12A: 155 - 161

Edmonds M, Boulton A, Buckenham T, et al. Report of the Diabetic Foot and Amputation Group. Diabet Med 1996; 13: S27 - 42

Foot Examination -an interactive guide; Aust Prescr 2002; 25:8 - 10

Relational attributes

Related metadata references: Supersedes Person—peripheral neuropathy 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:

The most important aspect of grading diabetic neuropathy from a foot ulceration point of view is to assess the degree of loss of sensation in the feet.

Diabetic neuropathy tends to occur in the setting of long-standing hyperglycaemia.
Peripheral neuropathy, which affects about 30% of people with either type 1 or type 2 diabetes, is the major predisposing disorder for diabetic foot disease. Peripheral neuropathy in feet results in loss of sensation and autonomic dysfunction. Neuropathy can occur either alone (neuropathic feet) or in combination with peripheral vascular disease causing ischaemia (neuro-ischaemic feet). Purely ischaemic feet are unusual, but are managed in the same way as neuro-ischaemic feet (see Australian Diabetes Society - Position Statement - The Lower Limb in People With Diabetes).

As stated by Duffy and others, the rate of lower extremity amputations can be reduced by 50% by the institution of monofilament testing in a preventive care program.

Diabetes polyneuropathy is frequently asymptomatic but may be associated with numbness, tingling and paraesthesia in the extremities, and less often with hyperesthesias. The most common form is a distal, symmetric, predominantly sensory polyneuropathy, which begins and is usually most marked in the feet and legs.
If symptomatic neuropathy is present consult with endocrinologist or physician specialising in diabetes care since options are available for the relief of symptoms.

Peripheral nerve function should be checked at least yearly in the patient with diabetes.

Peripheral vascular disease in feet (status)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—peripheral vascular disease indicator (foot), code N
METeOR identifier:	302459
Registration status:	Health, Standard 21/09/2005
Definition:	Whether peripheral vascular disease is present in either foot, as represented by a code.
Data Element Concept:	Person—peripheral vascular disease indicator (foot)

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 peripheral vascular disease is present in either foot. CODE 2 No: Record if peripheral vascular disease is not present in either foot.
Collection methods:	If it is mild, peripheral vascular disease can be completely without symptoms. However, compromised blood supply in the long term could cause claudication (pain in the calf after walking for a distance or up an incline or stairs), rest pain or vascular ulceration. Physical examination is necessary to assess the peripheral vascular circulation. Purplish colour and cold temperature of feet are indications to suspect that the circulation may be impaired. Palpate pulses: The simplest method to estimate blood flow and to detect ischaemia to the lower extremities is palpation of the foot pulses (posterior tibial and dorsalis pedis arteries) in both feet. Note whether pulses are present or absent. If pulses in the foot can be clearly felt, the risk of foot ulceration due to vascular

disease is small.

Test capillary return:

A helpful confirmation sign of arterial insufficiency is pallor of the involved feet after 1 - 2 min of elevation if venous filling time is delayed beyond the normal limit of 15 sec.

Doppler probe:

If pulses cannot be palpated, apply a small hand-held Doppler, placed over the dorsalis pedis or posterior tibial arteries to detect pulses, quantify the vascular supply and listen to the quality of the signal.

When the foot pulses are very weak or not palpable, the risk assessment could be completed by measuring the ankle brachial index (ankle pressure/ brachial pressure). Normal ankle brachial index is 0.9 - 1.2. An ankle brachial index less than 0.6 indicates compromised peripheral circulation.

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—peripheral vascular disease status (foot), 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:

Peripheral vascular disease is the leading cause of occlusion of blood vessels of the extremities with increasing prevalence in individuals with hypertension, hypercholesterolemia and diabetes mellitus, and in cigarette smokers.

Peripheral vascular disease is estimated to occur 11 times more frequently and develop about 10 years earlier in people with diabetes.

Presence of symptomatic peripheral vascular disease requires an interdisciplinary approach including a vascular surgeon, an endocrinologist or physician specialising in diabetes care.

References:

Foot Examination - an interactive guide; Australian Prescriber

Person identifier

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—person identifier, XXXXXX[X(14)]
METeOR identifier:	290046
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005
Definition:	Person identifier unique within an establishment or agency.
Data Element Concept:	Person—person identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	XXXXXX[X(14)]
Maximum character length:	20

Data element attributes

Collection and usage attributes

Guide for use:	Individual agencies, establishments or collection authorities may use their own alphabetic, numeric or alphanumeric coding systems. Field cannot be blank.

Source and reference attributes

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:	Supersedes Person—person identifier (within establishment/agency), XXXXXX[X(14)] Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005
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 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

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

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

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

Information specific to this data set:
Field cannot be blank.

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:
Field cannot be blank.

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

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

Person identifier type—health care (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (identifier)—identifier type, geographic/administrative scope code A
METeOR identifier:	270053
Registration status:	Health, Standard 01/03/2005
Definition:	A code based on the geographical or administrative breadth of applicability of Person identifier.
Data Element Concept:	Person (identifier)—identifier type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A
Maximum character length:	1

Permissible values:

Value	Meaning
L	Local
A	Area/region/district
S	State or territory

Collection and usage attributes

Guide for use:

CODE L Local

This code is for an identifier that is applicable only inside the issuing health care establishment

CODE A Area/region/district

This code is for an identifier that is applicable to:

- all the area/region/district health care services but not across all services in the state or territory; or
- all of a specific health care service (e.g. community mental health) in an area/region/district health care services but not across all those services in the state or territory

CODE S State or territory

This code is for identifiers that are applicable across all state or territory health care services.

Data element attributes

Collection and usage attributes

Guide for use:

A person can have more than one person identifier. Each Person identifier must have an appropriate person identifier type code recorded.

Use this field to record only identifier type. It must not be used to record any other person related information.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS5017 Health Care Client Identification

Relational attributes

Related metadata references:	Supersedes Person identifier type - health care, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.73 KB)
Implementation in Data Set Specifications:	Health care client identification Health, Superseded 04/05/2005 Health care client identification DSS Health, Standard 04/05/2005

Physical activity sufficiency status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—physical activity sufficiency status, code N
METeOR identifier:	270054
Registration status:	Health, Standard 01/03/2005
Definition:	Sufficiency of moderate or vigorous physical activity to confer a health benefit, as represented by a code.
Data Element Concept:	Person—physical activity sufficiency status

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Sufficient
	2	Insufficient
	3	Sedentary
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

The clinician makes a judgment based on assessment of the person's reported physical activity history for a usual 7-day period where:

CODE 1:

Sufficient physical activity for health benefit for a usual 7-day period is calculated by summing the total minutes of walking, moderate and/or vigorous physical activity.

Vigorous physical activity is weighted by a factor of two to account for its greater intensity. Total minutes for health benefit need to be equal to or more than 150 minutes per week.

CODE 2:

Insufficient physical activity for health benefit is where the sum of the total minutes of walking, moderate and/or vigorous physical activity for a usual 7-day period is less than 150 minutes but more than 0 minutes.

CODE 3:

Sedentary is where there has been no moderate and/or vigorous physical activity during a usual 7-day period.

CODE 9:

There is insufficient information to more accurately define the person's physical activity sufficiency status or the information is not known.

Note: The National Heart Foundation of Australia and the National Physical Activity Guidelines for Australians describes moderate-intensity physical activity as causing a slight but noticeable, increase in breathing and heart rate and suggests that the person should be able to comfortably talk but not sing. Examples of moderate physical activity include brisk walking, low pace swimming, light to moderate intensity exercise classes. Vigorous physical activity is described as activity, which causes the person to 'huff and puff', and where talking in a full sentence between breaths is difficult.

Examples of vigorous physical activity include jogging, swimming (freestyle) and singles tennis.

Comments:

The above grouping subdivides a population into three mutually exclusive categories.

A sufficiently physically active person is a person who is physically active on a regular weekly basis equal to or in excess of that required for a health benefit. Sufficient physical activity for health results from participation in physical activity of adequate duration and intensity. Although there is no clear absolute threshold for health benefit, the accrual of 150 minutes of moderate (at least) intensity physical activity over a period of one week is thought to confer health benefit. Walking is included as a moderate intensity physical activity. Note that the 150 minutes of moderate physical activity should be made up of 30 minutes on most days of the week and this can be accumulated in 10 minute bouts (National Physical Activity Guidelines for Australians).

Health benefits can also be obtained by participation in vigorous physical activity, in approximate proportion to the total amount of activity performed, measured either as energy expenditure or minutes of physical activity (Pate et al. 1995).

Physical activity - health benefit for vigorous physical activity is calculated by:

- incorporating a weighted factor of 2, to account for its greater intensity
- summing the total minutes of walking, moderate and/or vigorous physical activity will then give an indication if a health benefit is likely.

Insufficient physical activity describes a person who engages in regular weekly physical activity but not to the level required for a health benefit through either moderate or vigorous physical activity.

A sedentary person is a person who does not engage in any regular weekly physical activity.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Origin: The National Heart Foundation of Australia's Physical Activity Policy, April 2001. National Physical Activity Guidelines For Australians, developed by the University of Western Australia & the Centre for Health Promotion

Relational attributes

Related metadata references: Supersedes Physical activity sufficiency status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.53 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

Place of occurrence of external cause of injury (ICD-10-AM)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—place of occurrence, code (ICD-10-AM 6th edn) ANN{.N[N]}
METeOR identifier:	361677
Registration status:	Health, Standard 05/02/2008
Definition:	The place where the external cause of injury, poisoning or adverse effect occurred, as represented by a code.
Data Element Concept:	Injury event—place of occurrence

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:	Admitted patient: Use External Causes of Morbidity and Mortality Place of Occurrence codes from the current edition of ICD-10-AM. Used with all ICD-10-AM external cause codes and assigned according to the Australian Coding Standards. 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. Necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research.

Source and reference attributes

Origin:	National Health Data Committee National Centre for Classification in Health AIHW National Injury Surveillance Unit National Data Standards for Injury Surveillance Advisory Group

Relational attributes

Related metadata references:

Supersedes Injury event—place of occurrence, 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:
To be used with ICD-10-AM external cause codes.

Injury surveillance DSS Health, Standard 05/02/2008

Place of occurrence of external cause of injury (non-admitted patient)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—place of occurrence, non-admitted patient code N[N]
METeOR identifier:	268949
Registration status:	Health, Standard 01/03/2005
Definition:	The place where the external cause of injury, poisoning or adverse effect occurred, as represented by a code.
Data Element Concept:	Injury event—place of occurrence

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

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

Supplementary values:

9	Unspecified place

Data element attributes

Collection and usage attributes

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

one that comes first in the code list.

Source and reference attributes

Origin:
National Centre for Classification in Health
AIHW National Injury Surveillance Unit
National Data Standards for Injury Surveillance Advisory Group
National Health Data Committee

Relational attributes

Related metadata references:
Supersedes Place of occurrence of external cause of injury, version 6, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.14 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

Postal delivery point identifier (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—postal delivery point identifier, {N(8)}
METeOR identifier:	287220
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005
Definition:	A unique number assigned to a person's postal address as recorded on the Australia Post Postal Address File (PAF).
Data Element Concept:	Person (address)—postal delivery point identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	Number
Format:	{N(8)}
Maximum character length:	8

Source and reference attributes

Origin:	Customer Barcoding Technical Specifications, 1998: Australia Post
Reference documents:	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Data element attributes

Collection and usage attributes

Guide for use:	Australia Post maintains a Postal Address File (PAF) database which contains Australian postal delivery addresses and their corresponding eight (8) character unique identification number known as a Delivery Point Identifier (DPID). While the PAF is concerned with postal address, for many persons' a postal address will be the same as their residential address. The PAF can be used to improve the recording of address data at the time of data collection. The Postal Address File may be used at the time of data collection to confirm that the combined metadata items of address line, suburb/town/locality, Australian state/territory identifier and postcode - Australian are accurately recorded.
Collection methods:	The Delivery Point Identifier (DPID) is assigned electronically to recognised Australia Post delivery addresses following reference to the Postal Address File (PAF) database.
Comments:	In October 1999, Australia Post introduced a bar-coding system for bulk mail lodgements. Agencies or establishments can use software to improve the quality of person address data it collects and records and, at the same time, receive financial

benefits by reducing its postage expenses.

The DPID is easily converted to a bar code and can be included on correspondence and address labels. If the bar code is displayed on a standard envelope that passes through a mail-franking machine (e.g. as used by most major hospitals), the postage cost is reduced. Every three months, Australia Post provides updates to the PAF database. For more information, contact Australia Post.

Source and reference attributes

Submitting organisation: Standards Australia

Origin: National Health Data Standards Committee

National Community Services Data Committee

Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Relational attributes

Related metadata references: Is formed using Person (address)—suburb/town/locality name, text [A(50)] Health, Standard 04/05/2005, Community services, Standard 25/08/2005

Supersedes Person (address)—postal delivery point identifier, {N(8)} Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005

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

Postal delivery point identifier (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—postal delivery point identifier, {N(8)}
METeOR identifier:	290141
Registration status:	Health, Standard 04/05/2005 Community services, Standard 31/08/2005
Definition:	A unique number assigned to a service provider organisation's postal address as recorded on the Australia Post Postal Address File (PAF).
Data Element Concept:	Service provider organisation (address)—postal delivery point identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	Number
Format:	{N(8)}
Maximum character length:	8

Source and reference attributes

Origin:	Customer Barcoding Technical Specifications, 1998: Australia Post
Reference documents:	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Data element attributes

Collection and usage attributes

Collection methods:	The Delivery Point Identifier (DPID) is assigned electronically to recognised Australia Post delivery addresses following reference to the Postal Address File (PAF) database.
Comments:	In October 1999, Australia Post introduced a bar-coding system for bulk mail lodgements. Agencies or establishments can use software to improve the quality of person address data it collects and records and, at the same time, receive financial benefits by reducing its postage expenses. The DPID is easily converted to a bar code and can be included on correspondence and address labels. If the bar code is displayed on a standard envelope that passes through a mail-franking machine (e.g. as used by most major hospitals), the postage cost is reduced. Every three months, Australia Post provides updates to the PAF database. For more information, contact Australia Post.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	National Health Data Standards Committee National Community Services Data Committee Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Relational attributes

Related metadata references:	Is formed using Service provider organisation (address) – suburb/town/locality name, text [A(50)] Health, Standard 04/05/2005, Community services, Standard 31/08/2005
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

Postal delivery service number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—postal delivery service type identifier, [X(11)]
METeOR identifier:	270032
Registration status:	Health, Standard 01/03/2005
Definition:	An identifier for the postal delivery service where a person is located.
Data Element Concept:	Person (address)—postal delivery service type identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	[X(11)]
Maximum character length:	11

Data element attributes

Collection and usage attributes

Guide for use:	The identification of a postal delivery service may be composed of a prefix, a number, and a suffix as per the following format: Prefix A(3) Number N(5) Suffix A(3) May optionally include a prefix and suffix which are non-numeric. The identification may also not be required for certain services. Examples: PO BOX C96 CARE PO RMB 123 GPO BOX 1777Q
Collection methods:	To be collected in conjunction with Postal delivery service type - abbreviation.

Source and reference attributes

Origin:	Health Data Standards Committee AS4590 Interchange of client information

Relational attributes

Related metadata references:	Supersedes Postal delivery service number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.3 KB)

Postal delivery service type - abbreviation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—postal delivery service type, code AA[A(9)]
METeOR identifier:	270027
Registration status:	Health, Standard 01/03/2005
Definition:	Type of postal delivery service for a person, as represented by a code.
Data Element Concept:	Person—postal delivery service type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	AA[A(9)]
Maximum character length:	11

Permissible values:

Value	Meaning
CARE PO	Care-of Post Office (also known as Poste Restante)
CMA	Community Mail Agent
CMB	Community Mail Bag
GPO BOX	General Post Office Box
LOCKED BAG	Locked Mail Bag Service
MS	Mail Service
PO BOX	Post Office Box
PRIVATE BAG	Private Mail Bag Service
RSD	Roadside Delivery
RMB	Roadside Mail Box/Bag
RMS	Roadside Mail Service

Collection and usage attributes

Collection methods:	To be collected in conjunction with Person (address)—postal delivery service type identifier, [X(11)] when applicable.

Source and reference attributes

Origin:	AS4590 Interchange of client information

Data element attributes

Source and reference attributes

Origin:	Health Data Standards Committee

Relational attributes

Related metadata references:	Supersedes Postal delivery service type - abbreviation, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.48 KB)

Postcode—Australian (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—Australian postcode, code (Postcode datafile) {NNNN}
METeOR identifier:	287224
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 10/02/2006
Definition:	The numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of a person.
Data Element Concept:	Person (address)—Australian postcode

Value domain attributes

Representational attributes

Classification scheme:	Postcode datafile
Representation class:	Code
Data type:	Number
Format:	{NNNN}
Maximum character length:	4

Collection and usage attributes

Comments:

Postcode - Australian may be used in the analysis of data on a geographical basis, which involves a conversion from postcodes to the Australian Bureau of Statistics (ABS) postal areas. This conversion results in some inaccuracy of information. However, in some data sets postcode is the only geographic identifier, therefore the use of other more accurate indicators (e.g. Statistical Local Area (SLA)) is not always possible.

When dealing with aggregate data, postal areas, converted from postcodes, can be mapped to Australian Standard Geographical Classification codes using an ABS concordance, for example to determine SLAs. It should be noted that such concordances should not be used to determine the SLA of any individual's postcode. Where individual street addresses are available, these can be mapped to ASGC codes (e.g. SLAs) using the ABS National Localities Index (NLI).

Data element attributes

Collection and usage attributes

Guide for use:

The postcode book is updated more than once annually as postcodes are a dynamic entity and are constantly changing.

Collection methods:

Leave Postcode - Australian blank for:

- Any overseas address
- Unknown address
- No fixed address.

May be collected as part of Address line or separately. Postal

addresses may be different from where a person actually resides.

Source and reference attributes

Submitting organisation: Standards Australia

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

Australia Post Postcode book. Reference through:

http://www1.auspost.com.au/postcodes/

Relational attributes

Related metadata references: Supersedes Person (address) – Australian postcode (Postcode datafile), code NNN[N] Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005

See also Person – Australian state/territory identifier, code N Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 10/02/2006

Is used in the formation of Person – geographic location, community services code (ASGC 2004) NNNNN Community services, Superseded 02/05/2006

Is used in the formation of Dwelling – geographic location, remoteness structure code (ASGC 2004) N[N] Housing assistance, Retired 10/02/2006

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

Information specific to this data set:

The postcode can also be used in association with the Australian Bureau of Statistics Socio-Economic Indexes for Areas (SEIFA) index (Australian Bureau of Statistics Socio-Economic Indexes for Areas (SEIFA), Australia (CD-ROM) to derive socio-economic disadvantage, which is associated with cardiovascular risk.

People from lower socio-economic groups are more likely to die from cardiovascular disease than those from higher socio-economic groups. In 1997, people aged 25 - 64 living in the most disadvantaged group of the population died from cardiovascular disease at around twice the rate of those living in the least disadvantaged group (Australian Institute of Health and Welfare (AIHW) 2001. Heart, stroke and vascular diseases- Australian facts 2001.).

This difference in death rates has existed since at least the 1970s.

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

Information specific to this data set:

For data collection using Computer Assisted Telephone Interviewing (CATI) the suggested question is:

What is your postcode?

(Single response)

Enter Postcode

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

Postcode—Australian (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—Australian postcode, code (Postcode datafile) {NNNN}
METeOR identifier:	290064
Registration status:	Health, Standard 04/05/2005 Community services, Standard 31/08/2005
Definition:	The numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of an organisation, as represented by a code.
Data Element Concept:	Service provider organisation (address)—Australian postcode

Value domain attributes

Representational attributes

Classification scheme:	Postcode datafile
Representation class:	Code
Data type:	Number
Format:	{NNNN}
Maximum character length:	4

Collection and usage attributes

Comments:	Postcode - Australian may be used in the analysis of data on a geographical basis, which involves a conversion from postcodes to the Australian Bureau of Statistics (ABS) postal areas. This conversion results in some inaccuracy of information. However, in some data sets postcode is the only geographic identifier, therefore the use of other more accurate indicators (e.g. Statistical Local Area (SLA)) is not always possible. When dealing with aggregate data, postal areas, converted from postcodes, can be mapped to Australian Standard Geographical Classification codes using an ABS concordance, for example to determine SLAs. It should be noted that such concordances should not be used to determine the SLA of any individual's postcode. Where individual street addresses are available, these can be mapped to ASGC codes (e.g. SLAs) using the ABS National Localities Index (NLI).

Data element attributes

Collection and usage attributes

Collection methods:	May be collected as part of Address line or separately. Postal addresses may be different from where a service is actually located.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	National Health Data Committee

	National Community Services Data Committee Australia Post Postcode book. Reference through: http://www1.auspost.com.au/postcodes/
Reference documents:	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

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

Postcode—international (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—international postcode, text [X(10)]
METeOR identifier:	288985
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The code for a postal delivery area, aligned with locality, suburb or place for the address of a person, as defined by the postal service of a country other than Australia, as represented by text.
Data Element Concept:	Person (address)—international postcode

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(10)]
Maximum character length:	10

Data element attributes

Collection and usage attributes

Collection methods:	This is a self-reported code from a person and may be non-verifiable without reference to the specific country's coding rules. May be collected as part of Address or separately. Postal addresses may be different from where a person actually resides.

Source and reference attributes

Submitting organisation:	Standards Australia

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

Postcode—international (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—international postcode, text [X(10)]
METeOR identifier:	288987
Registration status:	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
Definition:	The code for a postal delivery area, aligned with locality, suburb or place for the address of an organisation, as defined by the postal service of a country other than Australia.
Data Element Concept:	Service provider organisation (address)—international postcode

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(10)]
Maximum character length:	10

Data element attributes

Collection and usage attributes

Collection methods:	This is a self-reported code from an organisation and may be non-verifiable without reference to the specific country's coding rules. May be collected as part of Address or separately. Postal addresses may be different from where a service is actually located.

Source and reference attributes

Submitting organisation:	Standards Australia

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

Postpartum complication

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—complication (postpartum), code (ICD-10-AM 6th edn) ANN{.N[N]}
METeOR identifier:	361067
Registration status:	Health, Standard 05/02/2008
Definition:	Medical and obstetric complications of the mother occurring during the postnatal period up to the time of separation from care, as represented by a code.
Data Element Concept:	Birth event—complication (postpartum)

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

Collection and usage attributes

Guide for use:	Complications and conditions should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM.

Data element attributes

Collection and usage attributes

Guide for use:	There is no arbitrary limit on the number of conditions specified.
Comments:	Examples of such conditions include postpartum haemorrhage, retained placenta, puerperal infections, puerperal psychosis, essential hypertension, psychiatric disorders, diabetes mellitus, epilepsy, cardiac disease and chronic renal disease. Complications of the puerperal period may cause maternal morbidity, and occasionally death, and may be an important factor in prolonging the duration of hospitalisation after childbirth.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee
Origin:	International Classification of Diseases - 10th Revision, Australian Modification (6th Edition 2005) National Centre for Classification in Health, Sydney.

Relational attributes

Related metadata references: Supersedes Birth event—complication (postpartum), code (ICD-10-AM 5th edn) ANN{.N[N]} Health, Superseded 05/02/2008