Admitted patient care NMDS 2007-2008

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List of metadata items

Data Element Technical Names

Metadata items

Admitted patient care NMDS 2007-2008

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	339089
Registration status:	NHIG, Standard 23/10/2006
DSS type:	National Minimum Data Set (NMDS)
Scope:	Episodes of care for admitted patients in all public and private acute and psychiatric hospitals, free standing day hospital facilities and alcohol and drug treatment centres in Australia. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore territories may also be included. Hospitals specialising in dental, ophthalmic aids and other specialised acute medical or surgical care are included. Hospital boarders and still births are not included as they are not admitted to hospital. Posthumous organ procurement episodes are also not included.

Collection and usage attributes

Statistical unit:	Episodes of care for admitted patients
Collection methods:	Data are collected at each hospital from patient administrative and clinical record systems. Hospitals forward data to the relevant state or territory health authority on a regular basis (e.g. monthly). *National reporting arrangements* State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis. *Periods for which data are collected and nationally collated* Financial years ending 30 June each year.
Implementation start date:	01/07/2007
Comments:	*Scope links with other NMDS* Episodes of care for admitted patients which occur partly or fully in designated psychiatric units of public acute hospitals or in public psychiatric hospitals: • Admitted patient mental health care NMDS. Episodes of care for admitted patients where care type is palliative care: • Admitted patient palliative care NMDS. *Glossary items* Some previous Knowledgebase data element concepts are available in the METeOR glossary. Glossary items are available online through links in the relevant metadata items. In addition links to the glossary terms that are relevant to this National minimum data set are listed below. **Admission** **Diagnosis** **Episode of acute care** **Hospital boarder** **Hospital-in-the-home care** **Live birth**

Neonate
Newborn qualification status
Organ procurement - posthumous
Same-day patient
Separation

Source and reference attributes

Origin: National Health Information Management Group

Relational attributes

Related metadata references: Supersedes Admitted patient care NMDS 2006-2007 NHIG, Superseded 23/10/2006

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Activity when injured	Mandatory	50
-	Additional diagnosis	Mandatory	50
-	Admission date	Mandatory	1
-	Admitted patient election status	Mandatory	1
-	Area of usual residence	Mandatory	1
-	Australian State/Territory identifier (establishment)	Mandatory	1
-	Care type	Mandatory	1
-	Country of birth	Mandatory	1
-	Date of birth	Mandatory	1
-	Diagnosis related group	Mandatory	1
-	Establishment number	Mandatory	1
-	Establishment sector	Mandatory	1
-	External cause (admitted patient)	Mandatory	50
-	Funding source for hospital patient	Mandatory	1
-	Hospital insurance status	Mandatory	1
-	Indigenous status	Mandatory	1
-	Intended length of hospital stay	Mandatory	1
-	Inter-hospital contracted patient	Mandatory	1
-	Major diagnostic category	Mandatory	1
-	Mental health legal status	Mandatory	1
-	Mode of admission	Mandatory	1
-	Mode of separation	Mandatory	1
-	Number of days of hospital-in-the-home care	Mandatory	1
-	Number of qualified days for newborns	Conditional	1
-	Person identifier	Mandatory	1
-	Place of occurrence of external cause of injury (ICD-10-AM)	Mandatory	50
-	Principal diagnosis	Mandatory	1
-	Procedure	Mandatory	50
-	Region code	Mandatory	1
-	Separation date	Mandatory	1

-	Sex	Mandatory	1
-	Source of referral to public psychiatric hospital	Conditional	1
-	Total leave days	Mandatory	1
-	Total psychiatric care days	Mandatory	1
-	Urgency of admission	Mandatory	1
-	Weight in grams (measured)	Conditional	1

Activity when injured

Identifying and definitional attributes

Technical name:	Injury event—activity type, code (ICD-10-AM 5th edn) ANNNN
METeOR identifier:	333849
Registration status:	NHIG, Standard 07/12/2005
Definition:	The type of activity being undertaken by the person when injured, for admitted patients, as represented by a code.

Data element concept attributes

Data element concept:	Injury event—activity type
Definition:	The type of activity being undertaken by the person when injured.
Context:	Injury surveillance
Object class:	Injury event
Property:	Activity type

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 5th edition
Representation class:	Code
Data type:	String
Format:	ANNNN
Maximum character length:	5

Data element attributes

Collection and usage attributes

Guide for use:	Use the appropriate External Causes of Morbidity and Mortality Activity codes from the current edition of ICD-10-AM. Used with 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. This term is the basis for identifying work-related and sport-related injuries.

Source and reference attributes

Origin:	National Centre for Classification in Health National Injury Surveillance Unit

Relational attributes

Related metadata references:	Supersedes Injury event—activity type, code (ICD-10-AM 4th edn) ANNNN NHIG, Superseded 07/12/2005
Implementation in Data Set Specifications:	Admitted patient care NMDS 2006-2007 NHIG, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006 Injury surveillance DSS NHIG, Standard 03/05/2006 Injury surveillance NMDS NHIG, Superseded 03/05/2006

Data set specification specific attributes

Implementation start date:	01/07/2007
Information specific to this data set:	To be used with ICD-10-AM external cause codes. Effective for collection from 01/07/2006

Additional diagnosis

Identifying and definitional attributes

Technical name:	Episode of care—additional diagnosis, code (ICD-10-AM 5th edn) ANN{.N[N]}
METeOR identifier:	333832
Registration status:	NHIG, Standard 07/12/2005
Definition:	A condition or complaint either coexisting with the principal diagnosis or arising during the episode of admitted patient care, episode of residential care or attendance at a health care establishment, as represented by a code.

Data element concept attributes

Data element concept:	Episode of care—additional diagnosis
Definition:	A condition or complaint either coexisting with the principal diagnosis or arising during the episode of admitted patient care, episode of residential care or attendance at a health care establishment.
Context:	Additional diagnoses give information on factors which result in increased length of stay, more intensive treatment or the use of greater resources. They are used for casemix analyses relating to severity of illness and for correct classification of patients into Australian Refined Diagnosis Related Groups (AR-DRGs).
Object class:	Episode of care
Property:	Additional diagnosis

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 5th 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:	Record each additional diagnosis relevant to the episode of care in accordance with the ICD-10-AM Australian Coding Standards. Generally, external cause, place of occurrence and activity codes will be included in the string of additional diagnosis codes. In some data collections these codes may also be copied into specific fields. The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status.

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

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

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

Source and reference attributes

Origin: National Centre for Classification in Health

Relational attributes

Related metadata references: Supersedes Episode of care—additional diagnosis, code (ICD-10-AM 4th edn) ANN{.N[N]} NHIG, Superseded 07/12/2005

Implementation in Data Set Specifications: ACT Health Morbidity Data Collection Specification 2006-2007 *No registration status*

AROC inpatient data set specification NHIG, Candidate 14/02/2007

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

Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006

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

Admitted patient mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

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

Admitted patient palliative care NMDS 2007-08 NHIG, Standard 23/10/2006

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

Residential mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

Data set specification specific attributes

Implementation start date: 01/07/2007

Information specific to this data set: An unlimited number of diagnosis and procedure codes should be able to be collected in hospital morbidity systems. Where this is not possible, a minimum of 20 codes should be able to be collected.

Effective for collection from 01/07/2006

Admission date

Identifying and definitional attributes

Technical name:	Episode of admitted patient care—admission date, DDMMYYYY
METeOR identifier:	269967
Registration status:	NHIG, Standard 01/03/2005
Definition:	Date on which an admitted patient commences an episode of care.

Data element concept attributes

Data element concept:	Episode of admitted patient care—admission date
Definition:	Date on which an admitted patient commences an episode of care.
Context:	Required to identify the period in which the admitted patient episode and hospital stay occurred and for derivation of length of stay.
Object class:	Episode of admitted patient care
Property:	Admission date

Value domain attributes

Representational attributes

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

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Admission date, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005 Is used in the formation of Episode of admitted patient care—length of stay (including leave days), total N[NN] *No registration status* Is used in the formation of Episode of admitted patient care—length of stay (including leave days) (antenatal), total N[NN] *No registration status* Is used in the formation of Major Diagnostic Category - supplied by hospital - code (AR-DRG v5.1) NN *No registration status* Is used in the formation of Episode of admitted patient care—length of stay (excluding leave days), total N[NN] NHIG, Standard 01/03/2005 Is used in the formation of Episode of care—number of

psychiatric care days, total N[NNNN] NHIG, Standard 01/03/2005

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

Is used in the formation of Episode of admitted patient care—length of stay (including leave days), total N[NN] NHIG, Standard 01/03/2005

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

Is used in the formation of Episode of admitted patient care (antenatal)—length of stay (including leave days), total N[NN] NHIG, Standard 01/03/2005

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

Is used in the formation of Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] NHIG, Standard 01/03/2005

Implementation in Data Set Specifications:

ACT Health Morbidity Data Collection Specification 2006-2007 *No registration status*

AROC inpatient data set specification NHIG, Candidate 14/02/2007

Acute coronary syndrome (clinical) DSS - Queensland Health CPIC *No registration status*

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

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

Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006

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

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

Admitted patient mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

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

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

Admitted patient palliative care NMDS 2007-08 NHIG, Standard 23/10/2006

Intensive care DSS NHIG, Recorded 14/07/2006

Organ and tissue donation *No registration status*

Data set specification specific attributes

Implementation start date: 01/07/2007

Information specific to this data set: Right justified and zero filled.

admission date ≤ separation date

admission date ≥ date of birth

Admitted patient election status

Identifying and definitional attributes

Technical name:	Episode of admitted patient care—patient election status, code N
METeOR identifier:	326619
Registration status:	NHIG, Standard 23/10/2006
Definition:	Accommodation chargeable status elected by a patient on **admission**, as represented by a code.

Data element concept attributes

Data element concept:	Episode of admitted patient care—patient election status
Definition:	Accommodation chargeable status elected by a patient on **admission**.
Context:	Admitted patient care.
Object class:	Episode of admitted patient care
Property:	Patient election status

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Public
2	Private

Collection and usage attributes

Guide for use:

Public patient:

A person, eligible for Medicare, who receives or elects to receive a public hospital service free of charge.

Includes: patients in public psychiatric hospitals who do not have the choice to be treated as a private patient. Also includes overseas visitors who are covered by a reciprocal health care agreement, and who elect to be treated as public patients.

Private patient:

A person who elects to be treated as a private patient and elects to be responsible for paying fees for the type referred to in clause 49 of the Australian Health Care Agreements (2003–2008).

Clause 49 states that:

Private patients, compensable patients and ineligible persons may be charged an amount for public hospital services as determined by (the state or territory).

All patients in private hospitals (other than those receiving public hospital services and electing to be treated as a public patient) are private patients.

Includes: all patients who are charged (regardless of the level of the charge) or for whom a charge is raised for a third party payer (for example, Department of Veterans' Affairs and Compensable patients). Also includes patients who are Medicare ineligible and receive public hospital services free of charge at the discretion of the hospital, and prisoners, who are Medicare ineligible while incarcerated.

Data element attributes

Collection and usage attributes

Guide for use:

Australian Health Care Agreements 2003–08 state that eligible persons are to be given the choice to receive, free of charge as public patients, health and emergency services.

At the time of, or as soon as practicable after, admission for a public hospital service, the patient must elect in writing to be treated as either

- a public patient or
- a private patient

This item is independent of the patient's hospital insurance status and room type.

Notes:

Inability to sign: In cases where the patient is unable to complete the patient election form, the patient should be assumed to be a public patient.

Compensation funding decisions: A patient may be recorded as a public patient as an interim patient election status while the patient's compensable status is being decided.

Inter-hospital contracted care: If the patient receives inter-hospital contracted care the following guidelines can be used if no further information is available:

- If the patient received contracted care that was purchased by a public hospital then it will be assumed that they elected to be treated as a public patient.
- If the patient received contracted care that was purchased by a private hospital then it will be assumed that they elected to be treated as a private patient.

Source and reference attributes

Submitting organisation: Admitted patient care NMDS Technical Reference Group

Relational attributes

Related metadata references: Supersedes Episode of admitted patient care—elected accommodation status, code N NHIG, Superseded 23/10/2006

Implementation in Data Set Specifications: Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006

Congenital anomalies NMDS (Under development by the NPSU September 2006) *No registration status*

Data set specification specific attributes

Implementation start date: 01/07/2007

Area of usual residence

Identifying and definitional attributes

Technical name:	Person—area of usual residence, geographical location code (ASGC 2006) NNNNN
METeOR identifier:	341800
Registration status:	NHIG, Standard 14/09/2006
Definition:	Geographical location of usual residence of the person, as represented by a code.

Data element concept attributes

Data element concept:	Person—area of usual residence
Definition:	Geographical location of usual residence of the person.
Object class:	Person
Property:	Area of usual residence

Value domain attributes

Representational attributes

Classification scheme:	Australian Standard Geographical Classification 2006
Representation class:	Code
Data type:	Number
Format:	NNNNN
Maximum character length:	5

Data element attributes

Collection and usage attributes

Guide for use:

The geographical location is reported using a five digit numerical code. The first digit is the single-digit code to indicate State or Territory. The remaining four digits are the numerical code for the Statistical Local Area (SLA) within the State or Territory.

The single digit codes for the states and territories and the four digit codes for the SLAs are as defined in the Australian Standard Geographical Classification (ASGC).

The ASGC is updated on an annual basis with a date of effect of 1 July each year. Therefore, the edition effective for the data collection reference year should be used.

The codes for SLA are unique within each State and Territory, but not within the whole country. Thus, to define a unique location, the code of the State or Territory is required in addition to the code for the SLA.

The Australian Bureau of Statistics '(ABS) National Localities Index (NLI) (ABS Catalogue number 1252.0) can be used to assign each locality or address in Australia to a SLA. The NLI is a comprehensive list of localities in Australia with their full code (including State or Territory and SLA) from the main structure of the ASGC.

For the majority of localities, the locality name (suburb or town, for example) is sufficient to assign a SLA. However, some localities have the same name. For most of these, limited additional information such as the postcode or State can be used with the locality name to assign the SLA. In addition, other localities cross one or more SLA boundaries and are referred to as split localities. For these, the more detailed information of the number and street of the person's residence is used with the Streets Sub-index of the NLI to assign the SLA.

If the information available on the person's address indicates that it is in a split locality but is insufficient to assign an SLA, the code for the SLA which includes most of the split locality should be reported. This is in accordance with the NLI assignment of SLA when a split locality is identified and further detail about the address is not available.

The NLI does not assign a SLA code if the information about the address is insufficient to identify a locality, or is not an Australian locality. In these cases, the appropriate codes for undefined SLA within Australia (State or Territory unstated), undefined SLA within a stated State or Territory, no fixed place of abode (within Australia or within a stated State or Territory) or overseas should be used.

Collection methods:

When collecting the geographical location of a person's usual place of residence, the Australian Bureau of Statistics (ABS) recommends that 'usual' be defined as: 'the place where the person has or intends to live for 6 months or more, or the place that the person regards as their main residence, or where the person has no other residence, the place they currently reside.' Apart from collecting a person's usual place of residence there is also a need in some collections to collect area of residence immediately prior to or after assistance is provided, or at some other point in time.

Comments:

Geographical location is reported using Statistical Local Area (SLA) to enable accurate aggregation of information to larger areas within the Australian Standard Geographical Classification (ASGC) (such as Statistical Subdivisions and Statistical Divisions) as well as detailed analysis at the SLA level. The use of SLA also allows analysis relating the data to information complied by the Australian Bureau of Statistics on the demographic and other characteristics of the population of each SLA. Analyses facilitates by the inclusion of SLA information include:

- comparison of the use of services by persons residing in different geographical areas,
- characterisation of catchment areas and populations for establishments for planning purposes, and
- documentation of the provision of services to residents of States or Territories other than the State or Territory of the provider.

Source and reference attributes

Origin: Health Data Standards Committee

Relational attributes

Related metadata references: Supersedes Person—area of usual residence, geographical

	location code (ASGC 2005) NNNNN NHIG, Superseded 14/09/2006
Implementation in Data Set Specifications:	Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006 Admitted patient mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006 Admitted patient palliative care NMDS 2007-08 NHIG, Standard 23/10/2006 Community mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006 Community-based palliative care client DSS *No registration status* Non-admitted patient emergency department care NMDS *No registration status* Non-admitted patient emergency department care NMDS 2007-2008 NHIG, Standard 23/10/2006 Organ and tissue donation *No registration status* Perinatal NMDS 2007-2008 NHIG, Standard 06/09/2006 Residential mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

Data set specification specific attributes

Implementation start date:	01/07/2007

Australian State/Territory identifier (establishment)

Identifying and definitional attributes

Technical name:	Establishment—Australian state/territory identifier, code N
METeOR identifier:	269941
Registration status:	NHIG, Standard 01/03/2005
Definition:	An identifier of the Australian state or territory in which an establishment is located, as represented by a code.

Data element concept attributes

Data element concept:	Establishment—Australian state/territory identifier
Definition:	An identifier of the Australian state or territory in which an establishment is located.
Object class:	Establishment
Property:	Australian state/territory identifier

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	New South Wales
2	Victoria
3	Queensland
4	South Australia
5	Western Australia
6	Tasmania
7	Northern Territory
8	Australian Capital Territory
9	Other territories (Cocos (Keeling) Islands, Christmas Island and Jervis Bay Territory)

Collection and usage attributes

Guide for use:	The order presented here is the standard for the Australian Bureau of Statistics (ABS). Other organisations (including the Australian Institute of Health and Welfare) publish data in state order based on population (that is, Western Australia before South Australia and Australian Capital Territory before Northern Territory).

Source and reference attributes

Reference documents:	Australian Bureau of Statistics 2005. Australian Standard Geographical Classification (ASGC). Cat. no. 1216.0. Canberra: ABS. Viewed on 30/09/2005

Data element attributes

Collection and usage attributes

Guide for use: This metadata item applies to the location of the establishment and not to the patient's area of usual residence.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: National Health Data Committee
National Community Services Data Committee

Relational attributes

Related metadata references: Supersedes Australian State/Territory identifier, version 4, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005
Is used in the formation of Service delivery outlet—geographic location, code (ASGC 2006) NNNNN NHIG, Standard 14/09/2006
Is used in the formation of Establishment—geographical location, code (ASGC 2006) NNNNN NHIG, Standard 14/09/2006
Is used in the formation of Establishment—geographical location, code (ASGC 2005) NNNNN NHIG, Superseded 14/09/2006
Is used in the formation of Service delivery outlet—geographic location, code (ASGC 2005) NNNNN NHIG, Superseded 14/09/2006
Is used in the formation of Establishment—organisation identifier (Australian), NNX[X]NNNNN NHIG, Standard 01/03/2005
Is used in the formation of Service delivery outlet—geographic location, code (ASGC 2004) NNNNN NHIG, Superseded 21/03/2006

Implementation in Data Set Specifications: Admitted patient care NMDS NHIG, Superseded 07/12/2005
Admitted patient care NMDS 2006-2007 NHIG, Superseded 23/10/2006
Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006
Community mental health care NMDS 2005-2006 NHIG, Superseded 07/12/2005
Community mental health care NMDS 2006-2007 NHIG, Superseded 23/10/2006
Community mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006
Mental health establishments NMDS 2005-2006 NHIG, Superseded 07/12/2005
Mental health establishments NMDS 2005-2006 NHIG, Superseded 21/03/2006
Mental health establishments NMDS 2006-2007 NHIG, Superseded 23/10/2006
Mental health establishments NMDS 2007-2008 NHIG, Standard 23/10/2006

Organ and tissue donation *No registration status*

Outpatient care patient level DSS *No registration status*

Residential mental health care NMDS NHIG, Proposed 15/08/2005

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

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

Residential mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

Test Establishment identifier data cluster *No registration status*

Data set specification specific attributes

Implementation start date:	01/07/2007
Information specific to this data set:	This data element applies to the location of the establishment and not to the patient's area of usual residence.

Care type

Identifying and definitional attributes

Technical name:	Hospital service—care type, code N[N].N
METeOR identifier:	270174
Registration status:	NHIG, Standard 01/03/2005
Definition:	The overall nature of a clinical service provided to an admitted patient during an episode of care (admitted care), or the type of service provided by the hospital for boarders or **posthumous organ procurement** (other care), as represented by a code.

Data element concept attributes

Data element concept:	Hospital service—care type
Definition:	The overall nature of a clinical service provided to an admitted patient during an episode of care (admitted care), or the type of service provided by the hospital for boarders or **posthumous organ procurement** (other care).
Context:	Admitted patient care and hospital activity: For admitted patients, the type of care received will determine the appropriate casemix classification employed to classify the episode of care.
Object class:	Hospital service
Property:	Care type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N].N
Maximum character length:	3

Permissible values:

Value	Meaning
1.0	Acute care (Admitted care)
2.0	Rehabilitation care (Admitted care)
2.1	Rehabilitation care delivered in a designated unit (optional)
2.2	Rehabilitation care according to a designated program (optional)
2.3	Rehabilitation care is the principal clinical intent (optional)
3.0	Palliative care
3.1	Palliative care delivered in a designated unit (optional)
3.2	Palliative care according to a designated program (optional)
3.3	Palliative care is the principal clinical intent (optional)

4.0	Geriatric evaluation and management
5.0	Psychogeriatric care
6.0	Maintenance care
7.0	Newborn care
8.0	Other admitted patient care
9.0	Organ procurement - posthumous (Other care)
10.0	Hospital boarder (Other care)

Collection and usage attributes

Guide for use:

Persons with mental illness may receive any one of the care types (except newborn and organ procurement). Classification depends on the principal clinical intent of the care received.

Admitted care can be one of the following:

CODE 1.0 Acute care (Admitted care)

Acute care is care in which the clinical intent or treatment goal is to:

- manage labour (obstetric)
- cure illness or provide definitive treatment of injury
- perform surgery
- relieve symptoms of illness or injury (excluding palliative care)
- reduce severity of an illness or injury
- protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function
- perform diagnostic or therapeutic procedures.

CODE 2.0 Rehabilitation care (Admitted care)

Rehabilitation care is care in which the clinical intent or treatment goal is to improve the functional status of a patient with an impairment, disability or handicap. It is usually evidenced by a multi-disciplinary rehabilitation plan comprising negotiated goals and indicative time frames which are evaluated by a periodic assessment using a recognised functional assessment measure. It includes care provided:

- in a designated rehabilitation unit (code 2.1), or
- in a designated rehabilitation program, or in a psychiatric rehabilitation program as designated by the state health authority for public patients in a recognised hospital, for private patients in a public or private hospital as approved by a registered health benefits organisation (code 2.2), or
- under the principal clinical management of a rehabilitation physician or, in the opinion of the treating doctor, when the principal clinical intent of care is rehabilitation (code 2.3).

Optional:

CODE 2.1 Rehabilitation care delivered in a designated unit (optional)

A designated rehabilitation care unit is a dedicated ward or unit (and can be a stand-alone unit) that receives identified funding for rehabilitation care and/or primarily delivers rehabilitation care.

CODE 2.2 Rehabilitation care according to a designated program (optional)

In a designated rehabilitation care program, care is delivered by a specialised team of staff who provide rehabilitation care to patients in beds that may or may not be dedicated to rehabilitation care. The program may, or may not be funded through identified rehabilitation care funding. Code 2.1 should be used instead of code 2.2 if care is being delivered in a designated rehabilitation care program and a designated rehabilitation care unit.

CODE 2.3 Rehabilitation care is the principal clinical intent (optional)

Rehabilitation as principal clinical intent (code 2.3) occurs when the patient is primarily managed by a medical practitioner who is a specialist in rehabilitation care or when, in the opinion of the treating medical practitioner, the care provided is rehabilitation care even if the doctor is not a rehabilitation care specialist. The exception to this is when the medical practitioner is providing care within a designated unit or a designated program, in which case code 2.1 or 2.2 should be used, respectively.

Code 3.0 Palliative care

Palliative care is care in which the clinical intent or treatment goal is primarily quality of life for a patient with an active, progressive disease with little or no prospect of cure. It is usually evidenced by an interdisciplinary assessment and/or management of the physical, psychological, emotional and spiritual needs of the patient; and a grief and bereavement support service for the patient and their carers/family. It includes care provided:

- in a palliative care unit (code 3.1); or
- in a designated palliative care program (code 3.2); or
- under the principal clinical management of a palliative care physician or, in the opinion of the treating doctor, when the principal clinical intent of care is palliation (code 3.3).

Optional:

CODE 3.1 Palliative care delivered in a designated unit (optional)

A designated palliative care unit is a dedicated ward or unit (and can be a stand-alone unit) that receives identified funding for palliative care and/or primarily delivers palliative care.

CODE 3.2 Palliative care according to a designated program (optional)

In a designated palliative care program, care is delivered by a specialised team of staff who provide palliative care to patients in beds that may or may not be dedicated to palliative care. The program may, or may not be funded through identified palliative care funding. Code 3.1 should be used instead of code 3.2 if care is being delivered in a designated palliative care program and a designated palliative care unit.

CODE 3.3 Palliative care is the principal clinical intent (optional)

Palliative care as principal clinical intent occurs when the patient is primarily managed by a medical practitioner who is a specialist in palliative care or when, in the opinion of the treating medical practitioner, the care provided is palliative care even if the doctor is not a palliative care specialist. The exception to this is when the medical practitioner is providing

care within a designated unit or a designated program, in which case code 3.1 or 3.2 should be used, respectively. For example, code 3.3 would apply to a patient dying of cancer who was being treated in a geriatric ward without specialist input by palliative care staff.

CODE 4.0 Geriatric evaluation and management

Geriatric evaluation and management is care in which the clinical intent or treatment goal is to maximise health status and/or optimise the living arrangements for a patient with multi-dimensional medical conditions associated with disabilities and psychosocial problems, who is usually (but not always) an older patient. This may also include younger adults with clinical conditions generally associated with old age. This care is usually evidenced by multi-disciplinary management and regular assessments against a management plan that is working towards negotiated goals within indicative time frames. Geriatric evaluation and management includes care provided:

- in a geriatric evaluation and management unit; or
- in a designated geriatric evaluation and management program; or
- under the principal clinical management of a geriatric evaluation and management physician or,
- in the opinion of the treating doctor, when the principal clinical intent of care is geriatric evaluation and management.

CODE 5.0 Psychogeriatric care

Psychogeriatric care is care in which the clinical intent or treatment goal is improvement in health, modification of symptoms and enhancement in function, behaviour and/or quality of life for a patient with an age-related organic brain impairment with significant behavioural or late onset psychiatric disturbance or a physical condition accompanied by severe psychiatric or behavioural disturbance. The care is usually evidenced by multi-disciplinary management and regular assessments against a management plan that is working towards negotiated goals within indicative time frames. It includes care provided:

- in a psychogeriatic care unit;
- in a designated psychogeriatic care program; or
- under the principal clinical management of a psychogeriatic physician or,
- in the opinion of the treating doctor, when the principal clinical intent of care is psychogeriatic care.

CODE 6.0 Maintenance care

Maintenance care is care in which the clinical intent or treatment goal is prevention of deterioration in the functional and current health status of a patient with a disability or severe level of functional impairment. Following assessment or treatment the patient does not require further complex assessment or stabilisation, and requires care over an indefinite period. This care includes that provided to a patient who would normally receive care in another setting eg at home, or in a residential aged care service, by a relative or carer, that is unavailable in the short term.

CODE 7.0 Newborn care

Newborn care is initiated when the patient is born in hospital or is nine days old or less at the time of admission. Newborn care continues until the care type changes or the patient is separated:

- patients who turn 10 days of age and do not require clinical care are separated and, if they remain in the hospital, are designated as boarders
- patients who turn 10 days of age and require clinical care continue in a newborn episode of care until separated
- patients aged less than 10 days and not admitted at birth (eg transferred from another hospital) are admitted with newborn care type
- patients aged greater than 9 days not previously admitted (eg transferred from another hospital) are either boarders or admitted with an acute care type
- within a newborn episode of care, until the baby turns 10 days of age, each day is either a qualified or unqualified day
- a newborn is qualified when it meets at least one of the criteria detailed in **Newborn qualification status**.

Within a newborn episode of care, each day after the baby turns 10 days of age is counted as a qualified patient day. Newborn qualified days are equivalent to acute days and may be denoted as such.

CODE 8.0 Other admitted patient care

Other admitted patient care is care where the principal clinical intent does meet the criteria for any of the above.

Other care can be one of the following:

CODE 9.0 Organ procurement - posthumous (Other care)

Organ procurement - posthumous is the procurement of human tissue for the purpose of transplantation from a donor who has been declared brain dead.

Diagnoses and procedures undertaken during this activity, including mechanical ventilation and tissue procurement, should be recorded in accordance with the relevant ICD-10-AM Australian Coding Standards. These patients are not admitted to the hospital but are registered by the hospital.

CODE 10.0 Hospital boarder (Other care)

Hospital boarder is a person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care.
Hospital boarders are not admitted to the hospital. However, a hospital may register a boarder. Babies in hospital at age 9 days of less cannot be boarders. They are admitted patients with each day of stay deemed to be either qualified or unqualified.

Comments: Unqualified newborn days (and separations consisting entirely of unqualified newborn days are not to be counted under the Australian Health Care Agreements and they are ineligible for health insurance benefit purposes.

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Care type, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005 Is used in the formation of Episode of care—number of psychiatric care days, total N[NNNN] NHIG, Standard 01/03/2005
Implementation in Data Set Specifications:	ACT Health Morbidity Data Collection Specification 2006-2007 *No registration status* Admitted patient care NMDS NHIG, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 NHIG, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006 Admitted patient mental health care NMDS NHIG, Superseded 07/12/2005 Admitted patient mental health care NMDS NHIG, Superseded 23/10/2006 Admitted patient mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006 Admitted patient palliative care NMDS NHIG, Superseded 07/12/2005 Admitted patient palliative care NMDS 2006-2007 NHIG, Superseded 23/10/2006 Admitted patient palliative care NMDS 2007-08 NHIG, Standard 23/10/2006

Data set specification specific attributes

Implementation start date:	01/07/2007

Country of birth

Identifying and definitional attributes

Technical name:	Person—country of birth, code (SACC 1998) NNNN
METeOR identifier:	270277
Registration status:	NHIG, Standard 01/03/2005 NCSIMG, Standard 01/03/2005 NHDAMG, Standard 20/06/2005
Definition:	The country in which the person was born, as represented by a code.

Data element concept attributes

Data element concept:	Person—country of birth
Definition:	The country in which the person was born.
Context:	Country of birth is important in the study of access to services by different population sub-groups. Country of birth is the most easily collected and consistently reported of a range of possible data items that may indicate cultural or language diversity. Country of birth may be used in conjunction with other data such as period of residence in Australia, etc., to derive more sophisticated measures of access to (or need for) services by different population sub-groups.
Object class:	Person
Property:	Country of birth

Value domain attributes

Representational attributes

Classification scheme:	Standard Australian Classification of Countries 1998
Representation class:	Code
Data type:	Number
Format:	NNNN
Maximum character length:	4

Collection and usage attributes

Guide for use:	The Standard Australian Classification of Countries 1998 (SACC) is a four-digit, three-level hierarchical structure specifying major group, minor group and country. A country, even if it comprises other discrete political entities such as states, is treated as a single unit for all data domain purposes. Parts of a political entity are not included in different groups. Thus, Hawaii is included in Northern America (as part of the identified country United States of America), despite being geographically close to and having similar social and cultural characteristics as the units classified to Polynesia.

Data element attributes

Collection and usage attributes

Collection methods:

Some data collections ask respondents to specify their country of birth. In others, a pre-determined set of countries is specified as part of the question, usually accompanied by an 'other (please specify)' category.

Recommended questions are:

In which country were you/was the person/was (name) born?

Australia

Other (please specify)

Alternatively, a list of countries may be used based on, for example common Census responses.

In which country were you/was the person/was (name) born?

Australia

England

New Zealand

Italy

Viet Nam

Scotland

Greece

Germany

Philippines

India

Netherlands

Other (please specify)

In either case coding of data should conform to the SACC.

Sometimes respondents are simply asked to specify whether they were born in either 'English speaking' or 'non-English speaking' countries but this question is of limited use and this method of collection is not recommended.

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.

Source and reference attributes

Origin:

National Health Data Committee

National Community Services Data Committee

Relational attributes

Related metadata references:

Supersedes Country of birth, version 4, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005

Implementation in Data Set Specifications:

ACT Health Morbidity Data Collection Specification 2006-2007 *No registration status*

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

Acute coronary syndrome (clinical) DSS *No registration status*

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

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

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

Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006

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

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

Admitted patient mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

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

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

Admitted patient palliative care NMDS 2007-08 NHIG, Standard 23/10/2006

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

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

Alcohol and other drug treatment services NMDS 2007-2008 NHIG, Standard 23/10/2006

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

Cardiovascular disease (clinical) DSS NHIG, Standard 15/02/2006

Cardiovascular disease (clinical) DSS - Demo for CPIC *No registration status*

Commonwealth State/Territory Disability Agreement NMDS 2006-2007 NCSIMG, Standardisation pending 27/03/2007

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

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

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

Community mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

Community-based palliative care client DSS *No registration status*

Computer Assisted Telephone Interview demographic module DSS *No registration status*

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

Congenital anomalies NMDS (Under development by the NPSU September 2006) *No registration status*

Gambling Support Services *No registration status*

Health care client identification NHIG, Superseded 04/05/2005

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

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

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

Non-admitted patient emergency department care NMDS *No registration status*

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

Non-admitted patient emergency department care NMDS 2007-2008 NHIG, Standard 23/10/2006

Organ and tissue donation *No registration status*

Outpatient care patient level DSS *No registration status*

Perinatal NMDS NHIG, Superseded 07/12/2005

Perinatal NMDS NHIG, Superseded 06/09/2006

Perinatal NMDS 2007-2008 NHIG, Standard 06/09/2006

Problem gambling NMDS *No registration status*

Residential mental health care NMDS NHIG, Proposed 15/08/2005

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

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

Residential mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

Supported Accommodation Assistance Program (SAAP) Client Collection NMDS NCSIMG, Proposed 14/04/2007

TEST sorting DSS *No registration status*

TEST sorting DSS (no clusters) *No registration status*

Data set specification specific attributes

Implementation start date: 01/07/2007

Date of birth

Identifying and definitional attributes

Technical name:	Person—date of birth, DDMMYYYY
METeOR identifier:	287007
Registration status:	NHIG, Standard 04/05/2005 NCSIMG, Standard 25/08/2005 NHDAMG, Standard 20/06/2005
Definition:	The date of birth of the person.

Data element concept attributes

Data element concept:	Person—date of birth
Definition:	The date of birth of the person.
Context:	Required for a range of clinical and administrative purposes. Date of birth enables derivation of age for use in demographic analyses, assists in the unique identification of clients if other identifying information is missing or in question, and may be required for the derivation of other metadata items (e.g. the diagnosis related group for admitted patients).
Object class:	Person
Property:	Date of birth

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	If date of birth is not known or cannot be obtained, provision should be made to collect or estimate age. Collected or estimated age would usually be in years for adults, and to the nearest three months (or less) for children aged less than two years. Additionally, an estimated date flag or a date accuracy indicator should be reported in conjunction with all estimated dates of birth. For data collections concerned with children's services, it is suggested that the estimated date of birth of children aged under 2 years should be reported to the nearest 3 month period, i.e. 0101, 0104, 0107, 0110 of the estimated year of birth. For example, a child who is thought to be aged 18 months in October of one year would have his/her estimated date of birth reported as 0104 of the previous year. Again, an estimated date flag or date accuracy indicator should be reported in conjunction with all estimated dates of birth.

Collection methods:

Information on date of birth can be collected using the one question:

What is your/(the person's) date of birth?

In self-reported data collections, it is recommended that the following response format is used:

Date of birth: _ _ / _ _ / _ _ _ _

This enables easy conversion to the preferred representational layout (DDMMYYYY).

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

Comments:

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

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

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

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

Source and reference attributes

Origin:

National Health Data Committee

National Community Services Data Committee

Reference documents:

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

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

Relational attributes

Related metadata references:

Supersedes Person—date of birth, DDMMYYYY NHIG, Superseded 04/05/2005, NCSIMG, Superseded 25/08/2005

Is used in the formation of Record—linkage key, code 581 XXXXXDDMMYYYYN NCSIMG, Recorded 27/03/2007

Is used in the formation of Record—linkage key 581, statistical code XXXXXDDMMYYYYN NCSIMG, Recorded 27/03/2007

Is used in the formation of Episode of admitted patient care—

length of stay (including leave days) (postnatal), total N[NN] *No registration status*

Is used in the formation of Episode of admitted patient care—length of stay (including leave days) (antenatal), total N[NN] *No registration status*

Is used in the formation of Person—statistical linkage key, XXXXXDDMMYYYYN NCSIMG, Proposed 19/07/2006

Is used in the formation of Major Diagnostic Category - supplied by hospital - code (AR-DRG v5.1) NN *No registration status*

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

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

Is used in the formation of Episode of admitted patient care (postnatal)—length of stay (including leave days), total N[NN] NHIG, Standard 01/03/2005

Is used in the formation of Episode of admitted patient care (antenatal)—length of stay (including leave days), total N[NN] NHIG, Standard 01/03/2005

Implementation in Data Set Specifications:

AROC inpatient data set specification NHIG, Candidate 14/02/2007

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

Acute coronary syndrome (clinical) DSS *No registration status*

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

Acute coronary syndrome (clinical) DSS - Queensland Health CPIC *No registration status*

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

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

Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006

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

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

Admitted patient mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

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

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

Admitted patient palliative care NMDS 2007-08 NHIG, Standard 23/10/2006

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

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

Alcohol and other drug treatment services NMDS 2007-2008 NHIG, Standard 23/10/2006

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

Cancer (clinical) DSS NHIG, Candidate 14/09/2006

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

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

Cardiovascular disease (clinical) DSS NHIG, Standard 15/02/2006

Cardiovascular disease (clinical) DSS - Demo for CPIC *No registration status*

Child protection NMDS *No registration status*

Commonwealth State/Territory Disability Agreement NMDS 2006-2007 NCSIMG, Standardisation pending 27/03/2007

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

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

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

Community mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

Community-based palliative care client DSS *No registration status*

Computer Assisted Telephone Interview demographic module DSS *No registration status*

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

Congenital anomalies NMDS (Under development by the NPSU September 2006) *No registration status*

Date of birth DSS *No registration status*

Dementia MDS *No registration status*

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

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

Gambling Support Services *No registration status*

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

Health care provider identification DSS NHIG, Standard 04/05/2005

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

Juvenile Justice NMDS 2005-06 NCSIMG, Standardisation pending 27/03/2007

Medical Indemnity DSS *No registration status*

National Bowel Screening Program NMDS *No registration status*

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

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

Non-admitted patient emergency department care NMDS *No registration status*

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

Non-admitted patient emergency department care NMDS 2007-2008 NHIG, Standard 23/10/2006

Organ and tissue donation *No registration status*

Outpatient care patient level DSS *No registration status*

Perinatal NMDS NHIG, Superseded 07/12/2005

Perinatal NMDS NHIG, Superseded 06/09/2006

Perinatal NMDS 2007-2008 NHIG, Standard 06/09/2006

Residential mental health care NMDS NHIG, Proposed 15/08/2005

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

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

Residential mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

SAAP date of birth data cluster *No registration status*

Statistical linkage key 581 cluster NCSIMG, Recorded 27/03/2007

Statistical linkage key DSS *No registration status*

Supported Accommodation Assistance Program (SAAP) Client Collection NMDS NCSIMG, Proposed 14/04/2007

Data set specification specific attributes

Implementation start date: 01/07/2007

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

National Minimum Data Sets:

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

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

Diagnosis related group

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Episode of admitted patient care—diagnosis related group
Definition:	A patient classification scheme which provides a means of relating the number and types of patients treated in a hospital to the resources required by the hospital.
Object class:	Episode of admitted patient care
Property:	Diagnosis related group

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

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

Relational attributes

Related metadata references:	See also Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN NHIG, Standard 01/03/2005 Is formed using Episode of care—mental health legal status, code N NHIG, Standard 01/03/2005 Is formed using Episode of admitted patient care—number of leave days, total N[NN] NHIG, Standard 01/03/2005

Is formed using Person—weight (measured), total grams NNNN NHIG, Standard 01/03/2005

Is formed using Person—date of birth, DDMMYYYY NHIG, Standard 04/05/2005, NCSIMG, Standard 25/08/2005, NHDAMG, Standard 20/06/2005

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

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

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

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

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

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

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

Is formed using Person—sex, code N NHIG, Standard 04/05/2005, NCSIMG, Standard 25/08/2005, NHDAMG, Standard 10/02/2006

Supersedes Diagnosis related group, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Implementation in Data Set Specifications:

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

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

Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006

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

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

Admitted patient mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

Data set specification specific attributes

Implementation start date: 01/07/2007

Establishment number

Identifying and definitional attributes

Technical name:	Establishment—organisation identifier (state/territory), NNNNN
METeOR identifier:	269975
Registration status:	NHIG, Standard 01/03/2005
Definition:	An identifier for an establishment, unique within the state or territory.

Data element concept attributes

Data element concept:	Establishment—organisation identifier (state/territory)
Definition:	An identifier for an establishment, unique within the state or territory.
Context:	All health services.
Object class:	Establishment
Property:	Organisation identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	Number
Format:	NNNNN
Maximum character length:	5

Data element attributes

Collection and usage attributes

Comments:	Identifier should be a unique code for the health care establishment used in that state/territory.

Relational attributes

Related metadata references:	Supersedes Establishment number, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005 Is used in the formation of Establishment—organisation identifier (Australian), NNX[X]NNNNN NHIG, Standard 01/03/2005
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS - Queensland Health CPIC *No registration status* Admitted patient care NMDS NHIG, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 NHIG, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006 Cancer (clinical) DSS NHIG, Superseded 07/12/2005 Cancer (clinical) DSS NHIG, Candidate 14/09/2006 Cancer (clinical) DSS NHIG, Standard 07/12/2005

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

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

Community mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

Health care client identification NHIG, Superseded 04/05/2005

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

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

Mental health establishments NMDS 2005-2006 NHIG, Superseded 21/03/2006

Mental health establishments NMDS 2006-2007 NHIG, Superseded 23/10/2006

Mental health establishments NMDS 2007-2008 NHIG, Standard 23/10/2006

Organ and tissue donation *No registration status*

Outpatient care patient level DSS *No registration status*

Residential mental health care NMDS NHIG, Proposed 15/08/2005

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

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

Residential mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

Test Establishment identifier data cluster *No registration status*

Data set specification specific attributes

Implementation start date: 01/07/2007

Establishment sector

Identifying and definitional attributes

Technical name:	Establishment—sector, code N
METeOR identifier:	269977
Registration status:	NHIG, Standard 01/03/2005
Definition:	A section of the health care industry with which a health care establishment can identify, as represented by a code.

Data element concept attributes

Data element concept:	Establishment—sector
Definition:	A section of the health care industry with which a health care establishment can identify.
Context:	Health services.
Object class:	Establishment
Property:	Sector

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Public
2	Private

Data element attributes

Collection and usage attributes

Guide for use:

Alcohol and other drug treatment services NMDS:

This data element is used to differentiate between establishments run by the government sector (code 1) and establishments that receive some government funding but are run by the non-government sector (code 2).

CODE 1 is to be used when the establishment:

- operates from the public accounts of a Commonwealth, state or territory government or is part of the executive, judicial or legislative arms of government,
- is part of the general government sector or is controlled by some part of the general government sector,
- provides government services free of charge or at nominal prices, and
- is financed mainly from taxation.

CODE 2 is to be used only when the establishment:

- is not controlled by government,
- is directed by a group of officers, an executive committee or

a similar body
- elected by a majority of members, and
- may be an income tax exempt charity.

Relational attributes

Related metadata references:

Supersedes Establishment sector, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005

Is used in the formation of Establishment—organisation identifier (Australian), NNX[X]NNNNN NHIG, Standard 01/03/2005

Implementation in Data Set Specifications:

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

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

Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006

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

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

Community mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

Health care client identification NHIG, Superseded 04/05/2005

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

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

Mental health establishments NMDS 2005-2006 NHIG, Superseded 21/03/2006

Mental health establishments NMDS 2006-2007 NHIG, Superseded 23/10/2006

Mental health establishments NMDS 2007-2008 NHIG, Standard 23/10/2006

Organ and tissue donation *No registration status*

Outpatient care patient level DSS *No registration status*

Residential mental health care NMDS NHIG, Proposed 15/08/2005

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

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

Residential mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

Test Establishment identifier data cluster *No registration status*

Data set specification specific attributes

Implementation start date: 01/07/2007

External cause (admitted patient)

Identifying and definitional attributes

Technical name:	Injury event—external cause, code (ICD-10-AM 5th edn) ANN{.N[N]}
METeOR identifier:	333853
Registration status:	NHIG, Standard 07/12/2005
Definition:	The environmental event, circumstance or condition as the cause of injury, poisoning and other adverse effect, as represented by a code.

Data element concept attributes

Data element concept:	Injury event—external cause
Definition:	Environmental event, circumstance or condition as the cause of injury, poisoning and other adverse effect.
Context:	Injury surveillance
Object class:	Injury event
Property:	External cause

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 5th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Source and reference attributes

Origin:	International Classification of Diseases - Tenth Revision - Australian Modification (5th Edition 2004) National Centre for Classification in Health, Sydney

Data element attributes

Collection and usage attributes

Guide for use:	This code must be used in conjunction with an injury or poisoning code and can be used with other disease codes. Admitted patients should be coded to the complete ICD-10-AM classification. An external cause code should be sequenced following the related injury or poisoning code, or following the group of codes, if more than one injury or condition has resulted from this external cause. Provision should be made to record more than one external cause if appropriate. External cause codes in the range W00 to Y34, except Y06 and Y07 must be accompanied by a place of occurrence code.

External cause codes V01 to Y34 must be accompanied by an activity code.

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

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

Source and reference attributes

Origin: National Centre for Classification in Health

National Data Standards for Injury Surveillance Advisory Group

National Health Data Committee

Relational attributes

Related metadata references: Supersedes Injury event—external cause, code (ICD-10-AM 4th edn) ANN{.N[N]} NHIG, Superseded 07/12/2005

Implementation in Data Set Specifications: Admitted patient care NMDS 2006-2007 NHIG, Superseded 23/10/2006

Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006

Injury surveillance DSS NHIG, Standard 03/05/2006

Injury surveillance NMDS NHIG, Superseded 03/05/2006

Data set specification specific attributes

Implementation start date: 01/07/2007

Information specific to this data set: As a minimum requirement, the external cause codes must be listed in the ICD-10-AM classification.

Effective for collection from 01/07/2006

Funding source for hospital patient

Identifying and definitional attributes

Technical name:	Episode of care—principal source of funding, hospital code NN
METeOR identifier:	339080
Registration status:	NHIG, Standard 29/11/2006
Definition:	The principal source of funds for an admitted patient episode or non-admitted patient service event, as represented by a code.
Context:	Admitted patient care. Hospital non-admitted patient care.

Data element concept attributes

Data element concept:	Episode of care—principal source of funding
Definition:	The principal source of funds for an admitted patient episode or non-admitted patient service event.
Object class:	Episode of care
Property:	Principal source of funding

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
01	Australian Health Care Agreements
02	Private health insurance
03	Self-funded
04	Worker's compensation
05	Motor vehicle third party personal claim
06	Other compensation (e.g. public liability, common law, medical negligence)
07	Department of Veterans' Affairs
08	Department of Defence
09	Correctional facility
10	Other hospital or public authority (contracted care)
11	Reciprocal health care agreements (with other countries)
12	Other
13	No charge raised

Supplementary values:

Value	Meaning
99	Not known

Collection and usage attributes

Guide for use:	CODE 01 Australian Health Care Agreements

Australian Health Care Agreements should be recorded as the funding source for Medicare eligible admitted patients who elect to be treated as public patients and Medicare eligible emergency department patients and Medicare eligible patients presenting at a public hospital outpatient department for whom there is not a third party arrangement.

Includes: Public admitted patients in private hospitals funded by state or territory health authorities (at the state or regional level).

Excludes: Inter-hospital contracted patients and overseas visitors who are covered by Reciprocal health care agreements and elect to be treated as public admitted patients.

CODE 02 Private health insurance

Excludes: overseas visitors for whom travel insurance is the major funding source.

CODE 03 Self-funded

This code includes funded by the patient, by the patient's family or friends, or by other benefactors.

CODE 10 Other hospital or public authority

Includes: Patients receiving treatment under contracted care arrangements (Inter-hospital contracted patient).

CODE 11 Reciprocal health care agreements (with other countries)

Australia has Reciprocal Health Care Agreements with the United Kingdom, the Netherlands, Italy, Malta, Sweden, Finland, Norway, New Zealand and Ireland. 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.

Excludes: Overseas visitors who elect to be treated as private patients.

CODE 12 Other funding source

Includes: Overseas visitors for whom travel insurance is the major funding source.

CODE 13 No charge

Includes: Admitted patients who are Medicare ineligible and receive public hospital services free of charge at the discretion of the hospital or the state/territory. Also includes patients who receive private hospital services for whom no accommodation or facility charge is raised (for example, when the only charges are for medical services bulk-billed to Medicare), and patients for whom a charge is raised but is subsequently waived.

Excludes: Admitted public patients (Medicare eligible) whose funding source should be recorded as Australian Health Care

Agreements or Reciprocal Health Care Agreements. Also excludes Medicare eligible non-admitted patients, presenting to a public hospital emergency department and Medicare eligible patients (for whom there is not a third party payment arrangement) presenting at a public hospital outpatient department, whose funding source should be recorded as Australian Health Care Agreements.

Also excludes patients presenting to an outpatient department who have chosen to be treated as a private patient and have been referred to a named medical specialist who is exercising a right of private practice. These patients are not considered to be patients of the hospital (see Guide for use).

Data element attributes

Collection and usage attributes

Guide for use:

If there is an expected funding source followed by a finalised actual funding source (for example, in relation to compensation claims), then the actual funding source known at the end of the reporting period should be recorded.

The expected funding source should be reported if the fee has not been paid but is not to be waived.

If a charge is raised for accommodation or facility fees for the episode/service event, the intent of this data element is to collect information on who is expected to pay, provided that the charge would cover most of the expenditure that would be estimated for the episode/service event. If the charge raised would cover less than half of the expenditure, then the funding source that represents the majority of the expenditure should be reported.

The major source of funding should be reported for nursing-home type patients.

Relational attributes

Related metadata references:

Supersedes Episode of care—expected principal source of funding, hospital code NN NHIG, Superseded 29/11/2006

Implementation in Data Set Specifications:

AROC inpatient data set specification NHIG, Candidate 14/02/2007

Acute coronary syndrome (2nd tier data items) *No registration status*

Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006

Admitted patient palliative care NMDS 2007-08 NHIG, Standard 23/10/2006

Data set specification specific attributes

Implementation start date:

01/07/2007

Hospital insurance status

Identifying and definitional attributes

Technical name: Patient—hospital insurance status, code N

METeOR identifier: 270253

Registration status: NHIG, Standard 01/03/2005

Definition: Hospital insurance as represented by a code under one of the following categories:

- Registered insurance - hospital insurance with a health insurance fund registered under the National Health Act 1953 (Cwlth)
- General insurance - hospital insurance with a general insurance company under a guaranteed renewable policy providing benefits similar to those available under registered insurance
- No hospital insurance or benefits coverage under the above.

Data element concept attributes

Data element concept: Patient—hospital insurance status

Definition: Hospital insurance under one of the following categories:

- Registered insurance - hospital insurance with a health insurance fund registered under the National Health Act 1953 (Cwlth)
- General insurance - hospital insurance with a general insurance company under a guaranteed renewable policy providing benefits similar to those available under registered insurance
- No hospital insurance or benefits coverage under the above.

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

Object class: Patient

Property: Hospital insurance status

Value domain attributes

Representational attributes

Representation class: Code

Data type: Number

Format: N

Maximum character length: 1

Permissible values:

Value	Meaning
1	Hospital insurance
2	No hospital insurance

Supplementary values:

9	Unknown

Data element attributes

Collection and usage attributes

Guide for use: Persons covered by insurance for benefits of ancillary services

only are included in 2 - no hospital insurance.

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

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

Comments:

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

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

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

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Hospital insurance status, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005

Implementation in Data Set Specifications: ACT Health Morbidity Data Collection Specification 2006-2007
No registration status

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

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

Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006

Data set specification specific attributes

Implementation start date: 01/07/2007

Indigenous status

Identifying and definitional attributes

Technical name:	Person—Indigenous status, code N
METeOR identifier:	291036
Registration status:	NHIG, Standard 04/05/2005 NCSIMG, Standard 25/08/2005
Definition:	Whether a person identifies as being of Aboriginal or Torres Strait Islander origin, as represented by a code. This is in accord with the first two of three components of the Commonwealth definition.

Data element concept attributes

Data element concept:	Person—Indigenous status
Definition:	Indigenous Status is a measure of whether a person identifies as being of Aboriginal or Torres Strait Islander origin. This is in accord with the first two of three components of the Commonwealth definition.
Context:	Australia's Aboriginal and Torres Strait Islander peoples occupy a unique place in Australian society and culture. In the current climate of reconciliation, accurate and consistent statistics about Aboriginal and Torres Strait Islander peoples are needed in order to plan, promote and deliver essential services, to monitor changes in wellbeing and to account for government expenditure in this area. The purpose of this metadata item is to provide information about people who identify as being of Aboriginal or Torres Strait Islander origin. Agencies or establishments wishing to determine the eligibility of individuals for particular benefits, services or rights will need to make their own judgments about the suitability of the standard measure for these purposes, having regard to the specific eligibility criteria for the program concerned.
Object class:	Person
Property:	Indigenous status

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Aboriginal but not Torres Strait Islander origin
2	Torres Strait Islander but not Aboriginal origin
3	Both Aboriginal and Torres Strait Islander origin
4	Neither Aboriginal nor Torres Strait Islander origin

Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

This metadata item is based on the Australian Bureau of Statistics (ABS) standard for Indigenous status. For detailed advice on its use and application please refer to the ABS Website as indicated in the Reference documents.

The classification for Indigenous status has a hierarchical structure comprising two levels. There are four categories at the detailed level of the classification which are grouped into two categories at the broad level. There is one supplementary category for 'not stated' responses. The classification is as follows:

Indigenous:

- Aboriginal but not Torres Strait Islander origin.
- Torres Strait Islander but not Aboriginal origin.
- Both Aboriginal and Torres Strait Islander origin.

Non-indigenous:

- Neither Aboriginal nor Torres Strait Islander origin.

Not stated/ inadequately described:

This category is not to be available as a valid answer to the questions but is intended for use:

- Primarily when importing data from other data collections that do not contain mappable data.
- Where an answer was refused.
- Where the question was not able to be asked prior to completion of assistance because the client was unable to communicate or a person who knows the client was not available.

Only in the last two situations may the tick boxes on the questionnaire be left blank.

Data element attributes

Collection and usage attributes

Collection methods:

The standard question for Indigenous Status is as follows:

[Are you] [Is the person] [Is (name)] of Aboriginal or Torres Strait Islander origin?

(For persons of both Aboriginal and Torres Strait Islander origin, mark both 'Yes' boxes.)

No.....

Yes, Aboriginal.....

Yes, Torres Strait Islander.....

This question is recommended for self-enumerated or interview-based collections. It can also be used in circumstances where a close relative, friend, or another member of the household is answering on behalf of the subject. It is strongly recommended that this question be asked directly wherever possible.

When someone is not present, the person answering for them should be in a position to do so, i.e. this person must know well the person about whom the question is being asked and feel confident to provide accurate information about them.

This question must always be asked regardless of data collectors' perceptions based on appearance or other factors.

The Indigenous status question allows for more than one response. The procedure for coding multiple responses is as follows:

If the respondent marks 'No' and either 'Aboriginal' or 'Torres Strait Islander', then the response should be coded to either Aboriginal or Torres Strait Islander as indicated (i.e. disregard the 'No' response).

If the respondent marks both the 'Aboriginal' and 'Torres Strait Islander' boxes, then their response should be coded to 'Both Aboriginal and Torres Strait Islander Origin'.

If the respondent marks all three boxes ('No', 'Aboriginal' and 'Torres Strait Islander'), then the response should be coded to 'Both Aboriginal and Torres Strait Islander Origin' (i.e. disregard the 'No' response).

This approach may be problematical in some data collections, for example when data are collected by interview or using screen based data capture systems. An additional response category

Yes, both Aboriginal and Torres Strait Islander...

may be included if this better suits the data collection practices of the agency or establishment concerned.

Comments:

The following definition, commonly known as 'The Commonwealth Definition', was given in a High Court judgement in the case of Commonwealth v Tasmania (1983) 46 ALR 625.

'An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she lives'.

There are three components to the Commonwealth definition:

- descent;
- self-identification; and
- community acceptance.

In practice, it is not feasible to collect information on the community acceptance part of this definition in general purpose statistical and administrative collections and therefore standard questions on Indigenous status relate to descent and self-identification only.

Source and reference attributes

Origin:

National Health Data Committee

National Community Services Data Committee

Reference documents:

Australian Bureau of Statistics 1999. Standards for Social, Labour and Demographic Variables. Cultural Diversity Variables, Canberra. Viewed 3 August 2005.

Relational attributes

Related metadata references:

Supersedes Person—Indigenous status, code N NHIG, Superseded 04/05/2005, NCSIMG, Superseded 25/08/2005

Implementation in Data Set Specifications:

AROC inpatient data set specification NHIG, Candidate 14/02/2007

Acute coronary syndrome (clinical) DSS NHIG, Standard

07/12/2005

Acute coronary syndrome (clinical) DSS *No registration status*

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

Acute coronary syndrome (clinical) DSS - Queensland Health CPIC *No registration status*

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

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

Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006

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

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

Admitted patient mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

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

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

Admitted patient palliative care NMDS 2007-08 NHIG, Standard 23/10/2006

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

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

Alcohol and other drug treatment services NMDS 2007-2008 NHIG, Standard 23/10/2006

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

Cardiovascular disease (clinical) DSS NHIG, Standard 15/02/2006

Cardiovascular disease (clinical) DSS - Demo for CPIC *No registration status*

Child protection NMDS *No registration status*

Commonwealth State/Territory Disability Agreement NMDS 2006-2007 NCSIMG, Standardisation pending 27/03/2007

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

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

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

Community mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

Community-based palliative care client DSS *No registration status*

Computer Assisted Telephone Interview demographic module DSS *No registration status*

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

Congenital anomalies NMDS (Under development by the NPSU September 2006) *No registration status*

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

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

Gambling Support Services *No registration status*

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

Juvenile Justice NMDS 2005-06 NCSIMG, Standardisation pending 27/03/2007

National Bowel Screening Program NMDS *No registration status*

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

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

Non-admitted patient emergency department care NMDS *No registration status*

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

Non-admitted patient emergency department care NMDS 2007-2008 NHIG, Standard 23/10/2006

Outpatient care patient level DSS *No registration status*

Perinatal NMDS NHIG, Superseded 07/12/2005

Perinatal NMDS NHIG, Superseded 06/09/2006

Perinatal NMDS 2007-2008 NHIG, Standard 06/09/2006

Recommended Data Specifications for Community Care *No registration status*

Residential mental health care NMDS NHIG, Proposed 15/08/2005

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

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

Residential mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

Supported Accommodation Assistance Program (SAAP) Client Collection NMDS NCSIMG, Proposed 14/04/2007

Data set specification specific attributes

Implementation start date: 01/07/2007

Intended length of hospital stay

Identifying and definitional attributes

Technical name:	Episode of admitted patient care—intended length of hospital stay, code N
METeOR identifier:	270399
Registration status:	NHIG, Standard 01/03/2005
Definition:	The intention of the responsible clinician at the time of the patient's **admission** to hospital or at the time the patient is placed on an elective surgery waiting list, to discharge the patient either on the day of admission or a subsequent date, as represented by a code.

Data element concept attributes

Data element concept:	Episode of admitted patient care—intended length of hospital stay
Definition:	The intention of the responsible clinician at the time of the patient's **admission** to hospital or at the time the patient is placed on an elective surgery waiting list, to discharge the patient either on the day of admission or a subsequent date.
Context:	Admitted patient care: To assist in the identification and casemix analysis of planned **same-day patients**, that is those patients who are admitted with the intention of discharge on the same day. This is also a key indicator for quality assurance activities.
Object class:	Episode of admitted patient care
Property:	Intended length of hospital stay

Collection and usage attributes

Comments:	Information comparing the intended length of the episode of care and the actual length of the episode of care is considered useful for quality assurance and utilisation review purposes.

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Intended same-day
2	Intended overnight

Data element attributes

Collection and usage attributes

Collection methods:	The intended length of stay should be ascertained for all admitted patients at the time the patient is admitted to hospital.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:
Supersedes Intended length of hospital stay, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005

Is used in the formation of Major Diagnostic Category - supplied by hospital - code (AR-DRG v5.1) NN *No registration status*

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

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

Implementation in Data Set Specifications:
ACT Health Morbidity Data Collection Specification 2006-2007 *No registration status*

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

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

Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006

Data set specification specific attributes

Implementation start date: 01/07/2007

Inter-hospital contracted patient

Identifying and definitional attributes

Technical name:	Episode of admitted patient care—inter-hospital contracted patient status, code N
METeOR identifier:	270409
Registration status:	NHIG, Standard 01/03/2005
Definition:	An episode of care for an admitted patient whose treatment and/or care is provided under an arrangement between a hospital purchaser of hospital care (contracting hospital) and a provider of an admitted service (contracted hospital), and for which the activity is recorded by both hospitals, as represented by a code.

Data element concept attributes

Data element concept:	Episode of admitted patient care—inter-hospital contracted patient status
Definition:	An episode of care for an admitted patient whose treatment and/or care is provided under an arrangement between a hospital purchaser of hospital care (contracting hospital) and a provider of an admitted service (contracted hospital), and for which the activity is recorded by both hospitals.
Context:	Admitted patient care: To identify patients receiving services that have been contracted between hospitals. This metadata item is used to eliminate potential double-counting of hospital activity in the analysis of patterns of health care delivery and funding and epidemiological studies.
Object class:	Episode of care
Property:	Inter-hospital contracted patient status

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Inter-hospital contracted patient from public sector hospital
2	Inter-hospital contracted patient from private sector hospital
3	Not contracted

Supplementary values:

Value	Meaning
9	Not reported

Data element attributes

Collection and usage attributes

Guide for use:

A specific arrangement should apply (either written or verbal) whereby one hospital contracts with another hospital for the provision of specific services. The arrangement may be between any combination of hospital; for example, public to public, public to private, private to private, or private to public.

This data element item will be derived as follows.

If Contract role = B (Hospital B, that is, the provider of the hospital service; contracted hospital), and Contract type = 2, 3, 4 or 5 (that is, a hospital (Hospital A) purchases the activity, rather than a health authority or other external purchaser, and admits the patient for all or part of the episode of care, and/or records the contracted activity within the patient's record for the episode of care). Then record a value of 1, if Hospital A is a public hospital or record a value of 2, if Hospital A is a private hospital.

Otherwise if the Contract role is not B, and/or the Contract type is not 2, 3, 4 or 5 record a value of 3.

Collection methods:

All services provided at both the originating and destination hospitals should be recorded and reported by the originating hospital. The destination hospital should record the admission as an 'Inter-hospital contracted patient' so that these services can be identified in the various statistics produced about hospital activity.

Source and reference attributes

Origin:

National Health Data Committee

Relational attributes

Related metadata references:

Is formed using Hospital—contract type, code N NHIG, Standard 01/03/2005

Is formed using Hospital—contract role, code A NHIG, Standard 01/03/2005

Supersedes Inter-hospital contracted patient, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005

Implementation in Data Set Specifications:

ACT Health Morbidity Data Collection Specification 2006-2007
No registration status

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

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

Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006

Data set specification specific attributes

Implementation start date:

01/07/2007

Major diagnostic category

Identifying and definitional attributes

Technical name:	Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN
METeOR identifier:	270400
Registration status:	NHIG, 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 attributes

Data element concept:	Episode of admitted patient care—major diagnostic category
Definition:	Major diagnostic categories (MDCs) are 23 mutually exclusive categories into which all possible principal diagnoses fall. The diagnoses in each category correspond to a single body system or aetiology, broadly reflecting the speciality providing care. Each category is partitioned according to whether or not a surgical procedure was performed. This preliminary partitioning into major diagnostic categories occurs before a diagnosis related group is assigned. The Australian refined diagnosis related groups (AR-DRGs) departs from the use of principal diagnosis as the initial variable in the assignment of some groups. A hierarchy of all exceptions to the principal diagnosis-based assignment to a MDC has been created. As a consequence, certain AR-DRGs are not unique to a MDC. This requires both a MDC and an AR-DRG to be generated per patient.
Context:	All admitted patient care contexts: The generation of a major diagnostic category to accompany each AR-DRG is a requirement of the latter as diagnosis related groups are not unique.
Object class:	Episode of admitted patient care
Property:	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—mental health legal status, code N NHIG, Standard 01/03/2005

Is formed using Episode of admitted patient care—number of leave days, total N[NN] NHIG, Standard 01/03/2005

Is formed using Person—weight (measured), total grams NNNN NHIG, Standard 01/03/2005

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

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

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

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

Is formed using Person—sex, code N NHIG, Standard 04/05/2005, NCSIMG, Standard 25/08/2005, NHDAMG, Standard 10/02/2006

See also Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA NHIG, Standard 01/03/2005

Supersedes Major diagnostic category, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

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

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

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

Is formed using Person—date of birth, DDMMYYYY NHIG, Standard 04/05/2005, NCSIMG, Standard 25/08/2005, NHDAMG, Standard 20/06/2005

Implementation in Data Set Specifications:

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

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

Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006

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

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

Admitted patient mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

Data set specification specific attributes

Implementation start date: 01/07/2007

Mental health legal status

Identifying and definitional attributes

Technical name:	Episode of care—mental health legal status, code N
METeOR identifier:	270351
Registration status:	NHIG, 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 attributes

Data element concept:	Episode of care—mental health legal status
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. Involuntary patients are persons who are detained in hospital or compulsorily treated in the community under mental health legislation for the purpose of assessment or provision of appropriate treatment or care.
Context:	Mental health care: This metadata item is required to monitor trends in the use of compulsory treatment provisions under State and Territory mental health legislation by Australian hospitals and community health care facilities, including 24-hour community based residential services. For those hospitals and community mental health services which provide psychiatric treatment to involuntary patients, mental health legal status information is an essential metadata item within local record systems.
Object class:	Episode of care
Property:	Mental health legal status

Collection and usage attributes

Guide for use:	Approval is required under the state or territory mental health legislation in order to detain patients for the provision of mental health care or for patients to be treated compulsorily in the community.

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 Major Diagnostic Category - supplied by hospital - code (AR-DRG v5.1) NN *No registration status*

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

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

Implementation in Data Set Specifications:
Admitted patient care NMDS NHIG, Superseded 07/12/2005

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

Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006

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

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

Admitted patient mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

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

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

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

Community mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

Residential mental health care NMDS NHIG, Proposed 15/08/2005

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

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

Residential mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

Data set specification specific attributes

Implementation start date: 01/07/2007

Mode of admission

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Episode of admitted patient care—admission mode
Definition:	Describes the mechanism by which a person begins an episode of care.
Context:	To assist in analyses of intersectoral patient flow and health care planning.
Object class:	Episode of admitted patient care
Property:	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

Implementation in Data Set Specifications:

ACT Health Morbidity Data Collection Specification 2006-2007
No registration status

AROC inpatient data set specification NHIG, Candidate 14/02/2007

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

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

Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006

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

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

Admitted patient palliative care NMDS 2007-08 NHIG, Standard 23/10/2006

Intensive care DSS NHIG, Recorded 14/07/2006

Data set specification specific attributes

Implementation start date: 01/07/2007

Mode of separation

Identifying and definitional attributes

Technical name:	Episode of admitted patient care—separation mode, code N
METeOR identifier:	270094
Registration status:	NHIG, 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 attributes

Data element concept:	Episode of admitted patient care—separation mode
Definition:	Status at **separation** of person (discharge/transfer/death) and place to which person is released (where applicable).
Context:	Required for outcome analyses, for analyses of intersectoral patient flows and to assist in the continuity of care and classification of episodes into diagnosis related groups.
Object class:	Episode of admitted patient care
Property:	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

Is used in the formation of Major Diagnostic Category - supplied by hospital - code (AR-DRG v5.1) NN *No registration status*

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

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

Implementation in Data Set Specifications:

ACT Health Morbidity Data Collection Specification 2006-2007 *No registration status*

AROC inpatient data set specification NHIG, Candidate 14/02/2007

Acute coronary syndrome (2nd tier data items) *No registration status*

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

Acute coronary syndrome (clinical) DSS *No registration status*

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

Acute coronary syndrome (clinical) DSS - Queensland Health CPIC *No registration status*

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

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

Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006

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

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

Admitted patient mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

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

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

Admitted patient palliative care NMDS 2007-08 NHIG,

Data set specification specific attributes

Implementation start date: 01/07/2007

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

Identifying and definitional attributes

Technical name:	Episode of admitted patient care—number of days of hospital-in-the-home care, total {N[NN]}
METeOR identifier:	270305
Registration status:	NHIG, 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 attributes

Data element concept:	Episode of admitted patient care—number of days of hospital-in-the-home care
Definition:	The number of **hospital-in-the-home** days occurring within an episode of care for an admitted patient.
Context:	Admitted patient care.
Object class:	Episode of admitted patient care
Property:	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

Implementation in Data Set Specifications: Admitted patient care NMDS NHIG, Superseded 07/12/2005

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

Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006

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

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

Admitted patient palliative care NMDS 2007-08 NHIG, Standard 23/10/2006

Data set specification specific attributes

Implementation start date: 01/07/2007

Number of qualified days for newborns

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Episode of admitted patient care (newborn)—number of qualified days
Definition:	The number of qualified newborn days occurring within a newborn episode of care.
Context:	Admitted patient care - newborn episodes of care only.
Object class:	Episode of admitted patient care
Property:	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 Is formed using Episode of admitted patient care (newborn)—date of change to qualification status, DDMMYYYY NHIG, Standard 01/03/2005 Is used in the formation of Establishment—number of patient days, total N[N(7)] NHIG, Standard 01/03/2005
Implementation in Data Set Specifications:	Admitted patient care NMDS NHIG, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 NHIG, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006

Data set specification specific attributes

Implementation start date:	01/07/2007

Person identifier

Identifying and definitional attributes

Technical name:	Person—person identifier, XXXXXX[X(14)]
METeOR identifier:	290046
Registration status:	NHIG, Standard 04/05/2005 NCSIMG, Standard 25/08/2005
Definition:	Person identifier unique within an establishment or agency.

Data element concept attributes

Data element concept:	Person—person identifier
Definition:	Person identifier unique within an establishment or agency.
Context:	This item could be used for editing at the agency, establishment or collection authority level and, potentially, for record linkage. There is no intention that this item would be available beyond collection authority level.
Object class:	Person
Property:	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)] NHIG, Superseded 04/05/2005, NCSIMG, Superseded 25/08/2005
Implementation in Data Set Specifications:	AROC inpatient data set specification NHIG, Candidate 14/02/2007 Acute coronary syndrome (clinical) DSS NHIG, Standard

07/12/2005

Acute coronary syndrome (clinical) DSS *No registration status*

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

Acute coronary syndrome (clinical) DSS - Queensland Health CPIC *No registration status*

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

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

Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006

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

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

Admitted patient mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

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

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

Admitted patient palliative care NMDS 2007-08 NHIG, Standard 23/10/2006

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

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

Alcohol and other drug treatment services NMDS 2007-2008 NHIG, Standard 23/10/2006

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

Cancer (clinical) DSS NHIG, Candidate 14/09/2006

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

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

Cardiovascular disease (clinical) DSS NHIG, Standard 15/02/2006

Cardiovascular disease (clinical) DSS - Demo for CPIC *No registration status*

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

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

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

Community mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

Congenital anomalies NMDS (Under development by the NPSU September 2006) *No registration status*

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

Health care provider identification DSS NHIG, Standard 04/05/2005

Intensive care DSS NHIG, Recorded 14/07/2006

Juvenile Justice NMDS 2005-06 NCSIMG, Standardisation pending 27/03/2007

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

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

Non-admitted patient emergency department care NMDS *No registration status*

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

Non-admitted patient emergency department care NMDS 2007-2008 NHIG, Standard 23/10/2006

Outpatient care patient level DSS *No registration status*

Perinatal NMDS NHIG, Superseded 07/12/2005

Perinatal NMDS NHIG, Superseded 06/09/2006

Perinatal NMDS 2007-2008 NHIG, Standard 06/09/2006

Residential mental health care NMDS NHIG, Proposed 15/08/2005

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

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

Residential mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

Data set specification specific attributes

Implementation start date: 01/07/2007

Place of occurrence of external cause of injury (ICD-10-AM)

Identifying and definitional attributes

Technical name:	Injury event—place of occurrence, code (ICD-10-AM 5th edn) ANN{.N[N]}
METeOR identifier:	333874
Registration status:	NHIG, Standard 07/12/2005
Definition:	The place where the external cause of injury, poisoning or adverse effect occurred, as represented by a code.

Data element concept attributes

Data element concept:	Injury event—place of occurrence
Definition:	The place where the external cause of injury, poisoning or adverse effect occurred.
Object class:	Injury event
Property:	Place of occurrence

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 5th 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 4th edn) ANN{.N[N]} NHIG, Superseded 07/12/2005
Implementation in Data Set Specifications:	Admitted patient care NMDS 2006-2007 NHIG, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006 Injury surveillance DSS NHIG, Standard 03/05/2006 Injury surveillance NMDS NHIG, Superseded 03/05/2006

Data set specification specific attributes

Implementation start date:	01/07/2007
Information specific to this data set:	To be used with ICD-10-AM external cause codes. Effective for collection from 01/07/2006

Principal diagnosis

Identifying and definitional attributes

Technical name:	Episode of care—principal diagnosis, code (ICD-10-AM 5th edn) ANN{.N[N]}
METeOR identifier:	333838
Registration status:	NHIG, Standard 07/12/2005
Definition:	The diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care, an episode of residential care or an attendance at the health care establishment, as represented by a code.

Data element concept attributes

Data element concept:	Episode of care—principal diagnosis
Definition:	The diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care, an episode of residential care or an attendance at the health care establishment.
Context:	Health services
Object class:	Episode of care
Property:	Principal diagnosis

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 5th 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:	The principal diagnosis must be determined in accordance with the Australian Coding Standards. Each episode of admitted patient care must have a principal diagnosis and may have additional diagnoses. The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status. As a minimum requirement the Principal diagnosis code must be a valid code from the current edition of ICD-10-AM. For episodes of admitted patient care, some diagnosis codes are too imprecise or inappropriate to be acceptable as a principal diagnosis and will group to 951Z, 955Z and 956Z in the Australian Refined Diagnosis Related Groups. Diagnosis codes starting with a V, W, X or Y, describing the

	circumstances that cause an injury, rather than the nature of the injury, cannot be used as principal diagnosis. Diagnosis codes which are morphology codes cannot be used as principal diagnosis.
Collection methods:	A principal diagnosis should be recorded and coded upon **separation**, for each episode of patient care. The principal diagnosis is derived from and must be substantiated by clinical documentation.
Comments:	The principal diagnosis is one of the most valuable health data elements. It is used for epidemiological research, casemix studies and planning purposes.

Source and reference attributes

Origin:	Health Data Standards Committee National Centre for Classification in Health National Data Standard for Injury Surveillance Advisory Group
Reference documents:	Bramley M, Peasley K, Langtree L and Innes K 2002. The ICD-10-AM Mental Health Manual: an integrated classification and diagnostic tool for community-based mental health services. Sydney: National Centre for Classification in Health, University of Sydney

Relational attributes

Related metadata references:	Supersedes Episode of care—principal diagnosis, code (ICD-10-AM 4th edn) ANN{.N[N]} NHIG, Superseded 07/12/2005
Implementation in Data Set Specifications:	ACT Health Morbidity Data Collection Specification 2006-2007 *No registration status* Acute coronary syndrome (2nd tier data items) *No registration status* Admitted patient care NMDS 2006-2007 NHIG, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006 Admitted patient mental health care NMDS NHIG, Superseded 23/10/2006 Admitted patient mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006 Admitted patient palliative care NMDS 2006-2007 NHIG, Superseded 23/10/2006 Admitted patient palliative care NMDS 2007-08 NHIG, Standard 23/10/2006 Community mental health care NMDS 2006-2007 NHIG, Superseded 23/10/2006 Community mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006 Residential mental health care NMDS 2006-2007 NHIG, Superseded 23/10/2006 Residential mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

Data set specification specific attributes

Implementation start date:	01/07/2007
Information specific to this data set:	The principal diagnosis is a major determinant in the

classification of Australian Refined Diagnosis Related Groups and Major Diagnostic Categories.

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

Effective for collection from 01/07/2006

Procedure

Identifying and definitional attributes

Technical name:	Episode of admitted patient care—procedure, code (ACHI 5th edn) NNNNN-NN
METeOR identifier:	333828
Registration status:	NHIG, Standard 07/12/2005
Definition:	A clinical intervention represented by a code that: • is surgical in nature, and/or • carries a procedural risk, and/or • carries an anaesthetic risk, and/or • requires specialised training, and/or • requires special facilities or equipment only available in an acute care setting.

Data element concept attributes

Data element concept:	Episode of admitted patient care—procedure
Definition:	A **clinical intervention** that: • is surgical in nature, and/or • carries a procedural risk, and/or • carries an anaesthetic risk, and/or • requires specialised training, and/or • requires special facilities or equipment only available in an acute care setting.
Context:	This metadata item gives an indication of the extent to which specialised resources, for example, human resources, theatres and equipment, are used. It also provides an estimate of the numbers of surgical operations performed and the extent to which particular procedures are used to resolve medical problems. It is used for classification of episodes of acute care for admitted patients into Australian refined diagnosis related groups.
Object class:	Episode of admitted patient care
Property:	Procedure

Value domain attributes

Representational attributes

Classification scheme:	Australian Classification of Health Interventions (ACHI) 5th edition
Representation class:	Code
Data type:	Number
Format:	NNNNN-NN
Maximum character length:	7

Data element attributes

Collection and usage attributes

Collection methods: Record and code all procedures undertaken during the episode of care in accordance with the ACHI (5th edition). Procedures are derived from and must be substantiated by clinical documentation.

Comments: The National Centre for Classification in Health advises the National Health Data Committee of relevant changes to the ACHI.

Source and reference attributes

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

Relational attributes

Related metadata references: Supersedes Episode of admitted patient care—procedure, code (ICD-10-AM 4th edn) NNNNN-NN NHIG, Superseded 07/12/2005

Implementation in Data Set Specifications: ACT Health Morbidity Data Collection Specification 2006-2007 *No registration status*
Admitted patient care NMDS 2006-2007 NHIG, Superseded 23/10/2006
Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006

Data set specification specific attributes

Implementation start date: 01/07/2007

Information specific to this data set: As a minimum requirement procedure codes must be valid codes from the Australian Classification of Health Interventions (ACHI) procedure codes and validated against the nationally agreed age and sex edits. More extensive edit checking of codes may be utilised within individual hospitals and state and territory information systems.

An unlimited number of diagnosis and procedure codes should be able to be collected in hospital morbidity systems. Where this is not possible, a minimum of 20 codes should be able to be collected.

Record all procedures undertaken during an episode of care in accordance with the ACHI (5th edition) Australian Coding Standards.

The order of codes should be determined using the following hierarchy:

- procedure performed for treatment of the principal diagnosis
- procedure performed for the treatment of an additional diagnosis
- diagnostic/exploratory procedure related to the principal diagnosis
- diagnostic/exploratory procedure related to an additional diagnosis for the episode of care.

Effective for collection from 01/07/2006

Region code

Identifying and definitional attributes

Technical name:	Establishment—region identifier, X[X]
METeOR identifier:	269940
Registration status:	NHIG, Standard 01/03/2005
Definition:	An alphanumeric identifier for the location of health services in a defined geographic or administrative area.

Data element concept attributes

Data element concept:	Establishment—region identifier
Definition:	An identifier for the location of health services in a defined geographic or administrative area.
Context:	All health services.
Object class:	Establishment
Property:	Region identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	X[X]
Maximum character length:	2

Data element attributes

Collection and usage attributes

Guide for use:	Domain values are specified by individual states/territories. Regions may also be known as Areas or Districts. Any valid region code created by a jurisdiction is permitted.

Relational attributes

Related metadata references:	Supersedes Region code, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005 Is used in the formation of Establishment—organisation identifier (Australian), NNX[X]NNNNN NHIG, Standard 01/03/2005
Implementation in Data Set Specifications:	Admitted patient care NMDS NHIG, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 NHIG, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006 Community mental health care NMDS 2005-2006 NHIG, Superseded 07/12/2005 Community mental health care NMDS 2006-2007 NHIG, Superseded 23/10/2006 Community mental health care NMDS 2007-2008 NHIG,

Standard 23/10/2006

Health care client identification NHIG, Superseded 04/05/2005

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

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

Mental health establishments NMDS 2005-2006 NHIG, Superseded 21/03/2006

Mental health establishments NMDS 2006-2007 NHIG, Superseded 23/10/2006

Mental health establishments NMDS 2007-2008 NHIG, Standard 23/10/2006

Outpatient care patient level DSS *No registration status*

Residential mental health care NMDS NHIG, Proposed 15/08/2005

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

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

Residential mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

Test Establishment identifier data cluster *No registration status*

Data set specification specific attributes

Implementation start date: 01/07/2007

Separation date

Identifying and definitional attributes

Technical name:	Episode of admitted patient care—separation date, DDMMYYYY
METeOR identifier:	270025
Registration status:	NHIG, Standard 01/03/2005
Definition:	Date on which an admitted patient completes an episode of care.

Data element concept attributes

Data element concept:	Episode of admitted patient care—separation date
Definition:	Date on which an admitted patient completes an episode of care.
Context:	Required to identify the period in which an admitted patient hospital stay or episode occurred and for derivation of length of stay.
Object class:	Episode of admitted patient care
Property:	Separation date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Comments:	There may be variations amongst jurisdictions with respect to the recording of separation date. This most often occurs for patients who are statistically separated after a period of leave (and who do not return for further hospital care). In this case, some jurisdictions may record the separation date as the date of statistical **separation** (and record intervening days as leave days) while other jurisdictions may retrospectively separate patients on the first day of leave. Despite the variations in recording of separation date for this group of patients, the current practices provide for the accurate recording of length of stay.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Separation date, version 5, DE, NHDD, NHIMG, Superseded 01/03/2005

Is used in the formation of Episode of admitted patient care—length of stay (including leave days), total N[NN] *No registration status*

Is used in the formation of Episode of admitted patient care—length of stay (including leave days) (postnatal), total N[NN] *No registration status*

Is used in the formation of Major Diagnostic Category - supplied by hospital - code (AR-DRG v5.1) NN *No registration status*

Is used in the formation of Episode of admitted patient care—length of stay (excluding leave days), total N[NN] NHIG, Standard 01/03/2005

Is used in the formation of Establishment—number of separations (financial year), total N[NNNNN] NHIG, Standard 01/03/2005

Is used in the formation of Episode of care—number of psychiatric care days, total N[NNNN] NHIG, Standard 01/03/2005

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

Is used in the formation of Episode of admitted patient care—length of stay (including leave days), total N[NN] NHIG, Standard 01/03/2005

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

Is used in the formation of Episode of admitted patient care (postnatal)—length of stay (including leave days), total N[NN] NHIG, Standard 01/03/2005

Implementation in Data Set Specifications:

ACT Health Morbidity Data Collection Specification 2006-2007 *No registration status*

AROC inpatient data set specification NHIG, Candidate 14/02/2007

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

Acute coronary syndrome (clinical) DSS *No registration status*

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

Acute coronary syndrome (clinical) DSS - Queensland Health CPIC *No registration status*

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

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

Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006

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

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

Admitted patient mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

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

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

Admitted patient palliative care NMDS 2007-08 NHIG, Standard 23/10/2006

Intensive care DSS NHIG, Recorded 14/07/2006

Perinatal NMDS NHIG, Superseded 07/12/2005

Perinatal NMDS NHIG, Superseded 06/09/2006

Perinatal NMDS 2007-2008 NHIG, Standard 06/09/2006

Data set specification specific attributes

Implementation start date: 01/07/2007

Information specific to this data set: For the provision of state and territory hospital data to Commonwealth agencies this field must:

- be ≤ last day of financial year
- be ≥ first day of financial year
- be ≤ Admission date

Sex

Identifying and definitional attributes

Technical name:	Person—sex, code N
METeOR identifier:	287316
Registration status:	NHIG, Standard 04/05/2005 NCSIMG, Standard 25/08/2005 NHDAMG, Standard 10/02/2006
Definition:	The biological distinction between male and female, as represented by a code.

Data element concept attributes

Data element concept:	Person—sex
Definition:	Sex is the biological distinction between male and female. Where there is an inconsistency between anatomical and chromosomal characteristics, sex is based on anatomical characteristics.
Context:	Sex is a core metadata item in a wide range of social, labour and demographic statistics.
Object class:	Person
Property:	Sex

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Male
2	Female
3	Intersex or indeterminate

Supplementary values:

Value	Meaning
9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Diagnosis and procedure codes should be checked against the national ICD-10-AM sex edits, unless the person is undergoing, or has undergone a sex change or has a genetic condition resulting in a conflict between sex and ICD-10-AM code.

CODE 3 Intersex or indeterminate

Intersex or indeterminate, refers to a person, who because of a genetic condition, was born with reproductive organs or sex chromosomes that are not exclusively male or female or whose sex has not yet been determined for whatever reason.

Intersex or indeterminate, should be confirmed if reported for people aged 90 days or greater.

Comments: The definition for Intersex in Guide for use is sourced from the

ACT Legislation (Gay, Lesbian and Transgender) Amendment Act 2003.

Source and reference attributes

Origin: Australian Capital Territory 2003. Legislation (Gay, Lesbian and Transgender) Amendment Act 2003

Reference documents: Legislation (Gay, Lesbian and Transgender) Amendment Act 2003. See http://www.legislation.act.gov.au/a/2003-14/20030328-4969/pdf/2003-14.pdf.

Data element attributes

Collection and usage attributes

Collection methods: Operationally, sex is the distinction between male and female, as reported by a person or as determined by an interviewer.

When collecting data on sex by personal interview, asking the sex of the respondent is usually unnecessary and may be inappropriate, or even offensive. It is usually a simple matter to infer the sex of the respondent through observation, or from other cues such as the relationship of the person(s) accompanying the respondent, or first name. The interviewer may ask whether persons not present at the interview are male or female.

A person's sex may change during their lifetime as a result of procedures known alternatively as sex change, gender reassignment, transsexual surgery, transgender reassignment or sexual reassignment. Throughout this process, which may be over a considerable period of time, the person's sex could be recorded as either Male or Female.

In data collections that use the ICD-10-AM classification, where sex change is the reason for admission, diagnoses should include the appropriate ICD-10-AM code(s) that clearly identify that the person is undergoing such a process. This code(s) would also be applicable after the person has completed such a process, if they have a procedure involving an organ(s) specific to their previous sex (e.g. where the patient has prostate or ovarian cancer).

CODE 3 Intersex or indeterminate

Is normally used for babies for whom sex has not been determined for whatever reason.

Should not generally be used on data collection forms completed by the respondent.

Should only be used if the person or respondent volunteers that the person is intersex or where it otherwise becomes clear during the collection process that the individual is neither male nor female.

CODE 9 Not stated/inadequately described

Is not to be used 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: Australian Institute of Health and Welfare (AIHW) National Mortality Database 1997/98 AIHW 2001 National Diabetes Register, Statistical Profile, December 2000 (Diabetes Series No.

2.)

Reference documents:

Australian Bureau of Statistics

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

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

In AS4846 and AS5017 alternative codes are presented. Refer to the current standard for more details.

Relational attributes

Related metadata references:

Supersedes Person—sex (housing assistance), code N NHDAMG, Superseded 10/02/2006

Supersedes Person—sex, code N NHIG, Superseded 04/05/2005, NCSIMG, Superseded 31/08/2005

Is used in the formation of Record—linkage key, code 581 XXXXXDDMMYYYYN NCSIMG, Recorded 27/03/2007

Is used in the formation of Record—linkage key 581, statistical code XXXXXDDMMYYYYN NCSIMG, Recorded 27/03/2007

Is used in the formation of Person—statistical linkage key, XXXXXDDMMYYYYN NCSIMG, Proposed 19/07/2006

Is used in the formation of Major Diagnostic Category - supplied by hospital - code (AR-DRG v5.1) NN *No registration status*

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

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

Implementation in Data Set Specifications:

ACT Health Morbidity Data Collection Specification 2006-2007 *No registration status*

AROC inpatient data set specification NHIG, Candidate 14/02/2007

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

Acute coronary syndrome (clinical) DSS *No registration status*

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

Acute coronary syndrome (clinical) DSS - Queensland Health CPIC *No registration status*

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

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

Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006

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

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

Admitted patient mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

Admitted patient palliative care NMDS NHIG, Superseded

07/12/2005

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

Admitted patient palliative care NMDS 2007-08 NHIG, Standard 23/10/2006

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

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

Alcohol and other drug treatment services NMDS 2007-2008 NHIG, Standard 23/10/2006

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

Cancer (clinical) DSS NHIG, Candidate 14/09/2006

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

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

Cardiovascular disease (clinical) DSS NHIG, Standard 15/02/2006

Cardiovascular disease (clinical) DSS - Demo for CPIC *No registration status*

Child protection NMDS *No registration status*

Commonwealth State/Territory Disability Agreement NMDS 2006-2007 NCSIMG, Standardisation pending 27/03/2007

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

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

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

Community mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

Community-based palliative care client DSS *No registration status*

Computer Assisted Telephone Interview demographic module DSS *No registration status*

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

Congenital anomalies NMDS (Under development by the NPSU September 2006) *No registration status*

Dementia MDS *No registration status*

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

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

Draft Needle and Syringe program client data dictionary *No registration status*

Gambling Support Services *No registration status*

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

Health care provider identification DSS NHIG, Standard 04/05/2005

Intensive care DSS NHIG, Recorded 14/07/2006

Juvenile Justice NMDS 2005-06 NCSIMG, Standardisation pending 27/03/2007

Medical Indemnity DSS *No registration status*

National Bowel Screening Program NMDS *No registration status*

National opioid pharmacotherapy statistics annual data *No registration status*

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

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

Non-admitted patient emergency department care NMDS *No registration status*

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

Non-admitted patient emergency department care NMDS 2007-2008 NHIG, Standard 23/10/2006

Organ and tissue donation *No registration status*

Outpatient care patient level DSS *No registration status*

Perinatal NMDS NHIG, Superseded 07/12/2005

Perinatal NMDS NHIG, Superseded 06/09/2006

Perinatal NMDS 2007-2008 NHIG, Standard 06/09/2006

Recommended Data Specifications for Community Care *No registration status*

Residential mental health care NMDS NHIG, Proposed 15/08/2005

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

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

Residential mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

Statistical linkage key 581 cluster NCSIMG, Recorded 27/03/2007

Statistical linkage key DSS *No registration status*

Test DSS *No registration status*

test *No registration status*

Data set specification specific attributes

Implementation start date: 01/07/2007

Source of referral to public psychiatric hospital

Identifying and definitional attributes

Technical name:	Episode of admitted patient care—referral source, public psychiatric hospital code NN
METeOR identifier:	269947
Registration status:	NHIG, Standard 01/03/2005
Definition:	Source from which the person was transferred/referred to the public psychiatric hospital, as represented by a code.
Context:	To assist in analyses of intersectoral patient flow and health care planning.

Data element concept attributes

Data element concept:	Episode of admitted patient care—referral source
Definition:	The source from which a patient is referred for an episode of admitted patient care.
Object class:	Episode of admitted patient care
Property:	Referral source

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
01	Private psychiatric practice
02	Other private medical practice
03	Other public psychiatric hospital
04	Other health care establishment
05	Other private hospital
06	Law enforcement agency
07	Other agency
08	Outpatient department
09	Other

Supplementary values:

Value	Meaning
10	Unknown

Data element attributes

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Source of referral to public psychiatric hospital, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005

Implementation in Data Set Specifications:

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

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

Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006

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

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

Admitted patient mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

Data set specification specific attributes

Implementation start date: 01/07/2007

Total leave days

Identifying and definitional attributes

Technical name:	Episode of admitted patient care—number of leave days, total N[NN]
METeOR identifier:	270251
Registration status:	NHIG, Standard 01/03/2005
Definition:	Sum of the length of leave (date returned from leave minus date went on leave) for all periods within the hospital stay.

Data element concept attributes

Data element concept:	Episode of admitted patient care—number of leave days
Definition:	Sum of the length of leave (date returned from leave minus date went on leave) for all periods within the hospital stay.
Context:	Recording of leave days allows for exclusion of these from the calculation of patient days. This is important for analysis of costs per patient and for planning. The maximum limit allowed for leave affects admission and **separation** rates, particularly for long-stay patients who may have several leave periods.
Object class:	Episode of admitted patient care
Property:	Number of leave days

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:

A day is measured from midnight to midnight.

The following rules apply in the calculation of leave days for both overnight and **same-day patients**:

- The day the patient goes on leave is counted as a leave day.
- The day the patient is on leave is counted as a leave day.
- The day the patient returns from leave is counted as a patient day.
- If the patient is admitted and goes on leave on the same day, this is counted as a patient day, not a leave day.
- If the patient returns from leave and then goes on leave again on the same day, this is counted as a leave day.
- If the patient returns from leave and is separated on the same day, the day should not be counted as either a patient day or a leave day.

Comments: It should be noted that for private patients in public and private hospitals, s.3 (12) of the Health Insurance Act 1973 (Cwlth) currently applies a different leave day count, Commonwealth Department of Human Services and Health HBF Circular 354 (31 March 1994). This metadata item was modified in July 1996 to exclude the previous differentiation between the psychiatric and other patients.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:
Supersedes Total leave days, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005

Is used in the formation of Major Diagnostic Category - supplied by hospital - code (AR-DRG v5.1) NN *No registration status*

Is used in the formation of Episode of admitted patient care—length of stay (excluding leave days), total N[NN] NHIG, Standard 01/03/2005

Is used in the formation of Episode of care—number of psychiatric care days, total N[NNNN] NHIG, Standard 01/03/2005

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

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

Implementation in Data Set Specifications:
ACT Health Morbidity Data Collection Specification 2006-2007 *No registration status*

AROC inpatient data set specification NHIG, Candidate 14/02/2007

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

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

Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006

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

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

Admitted patient mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

Data set specification specific attributes

Implementation start date: 01/07/2007

Information specific to this data set: For the provision of state and territory hospital data to Commonwealth agencies:

(Episode of admitted patient care—separation date, DDMMYYYY minus Episode of admitted patient care—admission date, DDMMYYYY) minus Admitted patient hospital stay—number of leave days, total N[NN] must be ≥ 0

days.

Total psychiatric care days

Identifying and definitional attributes

Technical name:	Episode of care—number of psychiatric care days, total N[NNNN]
METeOR identifier:	270300
Registration status:	NHIG, Standard 01/03/2005
Definition:	The sum of the number of days or part days of stay that the person received care as an admitted patient or **resident** within a designated psychiatric unit, minus the sum of leave days occurring during the stay within the designated unit.

Data element concept attributes

Data element concept:	Episode of care—number of psychiatric care days
Definition:	The sum of the number of days or part days of stay that the person received care as an admitted patient or **resident** within a designated psychiatric unit, minus the sum of leave days occurring during the stay within the designated unit.
Context:	Admitted patient and residential mental health care: This metadata item is required to identify the characteristics of patients treated in specialist psychiatric units located within acute care hospitals or 24-hour staffed community-based residential services and to analyse the activities of these units and services. Community mental health care: This metadata item is required to identify the characteristics of patients treated in specialist psychiatric 24-hour staffed community-based residential services and to analyse the activities of these units. The metadata item is necessary to describe and evaluate the progress of mainstreaming of mental health services.
Object class:	Episode of care
Property:	Number of psychiatric care 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:	Designated psychiatric units are staffed by health professionals with specialist mental health qualifications or training and have as their principal function the treatment and care of patients

affected by mental disorder. The unit may or may not be recognised under relevant State and Territory legislation to treat patients on an involuntary basis. Patients are admitted patients in the acute and psychiatric hospitals and residents in community based residences.

Public acute care hospitals:

Designated psychiatric units in public acute care hospitals are normally recognised by the State/Territory health authority in the funding arrangements applying to those hospitals.

Private acute care hospitals:

Designated psychiatric units in private acute care hospitals normally require license or approval by the State/Territory health authority in order to receive benefits from health funds for the provision of psychiatric care.

Psychiatric hospitals:

Total psychiatric care days in stand-alone psychiatric hospitals are calculated by counting those days the patient received specialist psychiatric care. Leave days and days on which the patient was receiving other care (e.g. specialised intellectual ability or drug and alcohol care) should be excluded.

Psychiatric hospitals are establishments devoted primarily to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders. Private hospitals formerly approved by the Commonwealth Department of Health under the Health Insurance Act 1973 (Commonwealth) (now licensed/approved by each State/Territory health authority), catering primarily for patients with psychiatric or behavioural disorders are included in this category.

Community-based residential services:

Designated psychiatric units refers to 24-hour staffed community-based residential units established in community settings that provide specialised treatment, rehabilitation or care for people affected by a mental illness or psychiatric disability. Special psychiatric units for the elderly are covered by this category, including psychogeriatric hostels or psychogeriatric nursing homes. Note that residences occupied by admitted patients located on hospital grounds, whether on the campus of a general or stand-alone psychiatric hospital, should be counted in the category of admitted patient services and not as community-based residential services.

Counting of patient days and leave days in designated psychiatric units should follow the standard definitions applying to these items.

For each period of care in a designated psychiatric unit, total days is calculated by subtracting the date on which care commenced within the unit from the date on which the specialist unit care was completed, less any leave days that occurred during the period.

Total psychiatric care days in 24-hour community-based residential care are calculated by counting those days the patient received specialist psychiatric care. Leave days and days on which the patient was receiving other care (e.g. specialised intellectual ability or drug and alcohol care) should be excluded.

Admitted patients in acute care:

Commencement of care within a designated psychiatric unit

may be the same as the date the patient was admitted to the hospital, or occur subsequently, following transfer of the patient from another hospital ward. Where commencement of psychiatric care occurs by transfer from another ward, a new episode of care may be recorded, depending on whether the care type has changed (see metadata item Care type). Completion of care within a designated psychiatric unit may be the same as the date the patient was discharged from the hospital, or occur prior to this on transfer of the patient to another hospital ward. Where completion of psychiatric care is followed by transfer to another hospital ward, a new episode of care may be recorded, depending on whether the care type has changed (see metadata item Care type. Total psychiatric care days may cover one or more periods in a designated psychiatric unit within the overall hospital stay.

Collection methods:

Accurate counting of total days in psychiatric care requires periods in designated psychiatric units to be identified in the person-level data collected by state or territory health authorities. Several mechanisms exist for this data field to be implemented:

- Ideally, the new data field should be collected locally by hospitals and added to the unit record data provided to the relevant state/territory health authority.
- Acute care hospitals in most states and territories include details of the wards in which the patient was accommodated in the unit record data provided to the health authority. Local knowledge should be used to identify designated psychiatric units within each hospital's ward codes, to allow total psychiatric care days to be calculated for each episode of care.
- Acute care hospitals and 24-hour staffed community-based residential services should be identified separately at the level of the establishment.

Comments:

This metadata item was originally designed to monitor trends in the delivery of psychiatric admitted patient care in acute care hospitals. It has been modified to enable collection of data in the community-based residential care sector. The metadata item is intended to improve understanding in this area and contribute to the ongoing evaluation of changes occurring in mental health services.

Source and reference attributes

Submitting organisation: National Mental Health Information Strategy Committee

Reference documents: Health Insurance Act 1973 (Commonwealth)

Relational attributes

Related metadata references:

Supersedes Total psychiatric care days, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005

Is formed using Establishment—establishment type, sector and services provided code AN.N{.N} NHIG, Standard 01/03/2005

Is formed using Hospital service—care type, code N[N].N NHIG, Standard 01/03/2005

Is formed using Episode of admitted patient care—number of leave days, total N[NN] NHIG, Standard 01/03/2005

Is formed using Episode of admitted patient care—admission

	date, DDMMYYYY NHIG, Standard 01/03/2005 Is formed using Episode of admitted patient care—separation date, DDMMYYYY NHIG, Standard 01/03/2005
Implementation in Data Set Specifications:	Admitted patient care NMDS NHIG, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 NHIG, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006 Admitted patient mental health care NMDS NHIG, Superseded 07/12/2005 Admitted patient mental health care NMDS NHIG, Superseded 23/10/2006 Admitted patient mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

Data set specification specific attributes

Implementation start date:	01/07/2007
Information specific to this data set:	Total days in psychiatric care must be: ≥ zero; and ≤ length of stay.

Urgency of admission

Identifying and definitional attributes

Technical name:	Episode of admitted patient care—admission urgency status, code N
METeOR identifier:	269986
Registration status:	NHIG, Standard 01/03/2005
Definition:	Whether the **admission** has an urgency status assigned and, if so, whether **admission** occurred on an emergency basis, as represented by a code.

Data element concept attributes

Data element concept:	Episode of admitted patient care—admission urgency status
Definition:	Whether the **admission** has an urgency status assigned and, if so, whether **admission** occurred on an emergency basis. An emergency admission is an admission of a patient for care or treatment which, in the opinion of the treating clinician, is necessary and admission for which should occur within 24 hours. An elective admission is an admission of a patient for care or treatment which, in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least 24 hours. Admissions for which an urgency status is usually not assigned are: • admissions for normal delivery (obstetric) • admissions which begin with the birth of the patient, or when it was intended that the birth occur in the hospital, commence shortly after the birth of the patient • statistical admissions • planned readmissions for the patient to receive limited care or treatment for a current condition, for example dialysis or chemotherapy.
Context:	Admitted patient care.
Object class:	Episode of admitted patient care
Property:	Admission urgency status

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Urgency status assigned - emergency
2	Urgency status assigned - elective
3	Urgency status not assigned

Supplementary values: 9 Not known/not reported

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Urgency status assigned - emergency

Emergency admission:

The following guidelines may be used by health professionals, hospitals and health insurers in determining whether an emergency admission has occurred. These guidelines should not be considered definitive.

An emergency admission occurs if one or more of the following clinical conditions are applicable such that the patient required admission within 24 hours.

Such a patient would be:

- at risk of serious morbidity or mortality and requiring urgent assessment and/or resuscitation; or
- suffering from suspected acute organ or system failure; or
- suffering from an illness or injury where the viability or function of a body part or organ is acutely threatened; or
- suffering from a drug overdoes, toxic substance or toxin effect; or
- experiencing severe psychiatric disturbance whereby the health of the patient or other people is at immediate risk; or
- suffering severe pain where the viability or function of a body part or organ is suspected to be acutely threatened; or
- suffering acute significant haemorrhage and requiring urgent assessment and treatment; or
- suffering gynaecological or obstetric complications; or
- suffering an acute condition which represents a significant threat to the patient's physical or psychological wellbeing; or
- suffering a condition which represents a significant threat to public health.

If an admission meets the definition of emergency above, it is categorised as emergency, regardless of whether the admission occurred within 24 hours of such a categorisation being made, or after 24 hours or more.

CODE 2 Urgency status assigned - Elective

Elective admissions:

If an admission meets the definition of elective above, it is categorised as elective, regardless of whether the admission actually occurred after 24 hours or more, or it occurred within 24 hours. The distinguishing characteristic is that the admission could be delayed by at least 24 hours.

Scheduled admissions:

A patient who expects to have an elective admission will often have that admission scheduled in advance. Whether or not the admission has been scheduled does not affect the categorisation of the admission as emergency or elective, which depends only on whether it meets the definitions above. That is, patients both with and without a scheduled admission can be admitted on either an emergency or elective basis.

Admissions from elective surgery waiting lists:

Patients on waiting lists for elective surgery are assigned a Clinical urgency status which indicates the clinical assessment of the urgency with which a patient requires elective hospital care. On admission, they will also be assigned an urgency of admission category, which may or may not be elective:

- Patients who are removed from elective surgery waiting lists on admission as an elective patient for the procedure for which they were waiting (see code 1 in metadata item Reason for removal from an elective surgery waiting list code N) will be assigned an Admission urgency status code N code of 2. In that case, their clinical urgency category could be regarded as further detail on how urgent their admission was.
- Patients who are removed from elective surgery waiting lists on admission as an emergency patient for the procedure for which they were waiting (see code 2 in metadata item Reason for removal from an elective surgery waiting list code N), will be assigned an Admission urgency status code N code of 1.

CODE 3 Urgency status not assigned

Admissions for which an urgency status is usually not assigned:

An urgency status can be assigned for admissions of the types listed above for which an urgency status is not usually assigned. For example, a patient who is to have an obstetric admission may have one or more of the clinical conditions listed above and be admitted on an emergency basis.

CODE 9 Not known/not reported

This code is used when it is not known whether or not an urgency status has been assigned, or when an urgency status has been assigned but is not known.

Source and reference attributes

Submitting organisation: Emergency definition working party

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Urgency of admission, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Implementation in Data Set Specifications: ACT Health Morbidity Data Collection Specification 2006-2007 *No registration status*

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

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

Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006

Data set specification specific attributes

Implementation start date: 01/07/2007

Weight in grams (measured)

Identifying and definitional attributes

Technical name:	Person—weight (measured), total grams NNNN
Synonymous names:	Infant weight, neonate, stillborn
METeOR identifier:	310245
Registration status:	NHIG, Standard 01/03/2005
Definition:	The weight (body mass) of a person measured in grams.

Data element concept attributes

Data element concept:	Person—weight
Definition:	The body mass of a person.
Context:	Public health and health care: Weight is an overall measure of body size that does not distinguish between fat and muscle. Weight is an indicator of nutrition status and health status. Low pre-pregnancy weight is an indicator of poorer gestational outcome in women (Kramer 1988). Low weight is also associated with osteoporosis. In general, change in weight is of interest in adults because it is an indicator of changing health status. Self reported or parentally reported weight for children and adolescents should be used cautiously if at all. It enables the calculation of body mass index which requires the measurement of height and weight (body mass) for adults.
Object class:	Person
Property:	Weight

Value domain attributes

Representational attributes

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

Data element attributes

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Is used in the formation of Major Diagnostic Category - supplied by hospital - code (AR-DRG v5.1) NN *No registration status* Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN NHIG, Standard 01/03/2005 Is used in the formation of Episode of admitted patient care—

	diagnosis related group, code (AR-DRG v5.1) ANNA NHIG, Standard 01/03/2005
Implementation in Data Set Specifications:	ACT Health Morbidity Data Collection Specification 2006-2007 *No registration status* Admitted patient care NMDS NHIG, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 NHIG, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006

Data set specification specific attributes

Implementation start date:	01/07/2007
Information specific to this data set:	For the provision of state and territory hospital data to Commonwealth agencies this metadata item must be consistent with diagnoses and procedure codes for valid grouping. Weight on the date the infant is admitted should be recorded if the weight is less than or equal to 9000g and age is less than 365 days.

Glossary items

Admission

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327206
Registration status:	NHIG, Standard 01/03/2005
Definition:	Admission is the process whereby the hospital accepts responsibility for the patient's care and/or treatment. Admission follows a clinical decision based upon specified criteria that a patient requires same-day or overnight care or treatment. An admission may be formal or statistical. Formal admission: The administrative process by which a hospital records the commencement of treatment and/or care and/or accommodation of a patient. Statistical admission: The administrative process by which a hospital records the commencement of a new episode of care, with a new care type, for a patient within one hospital stay.
Context:	Admitted patient care

Collection and usage attributes

Comments:	This treatment and/or care provided to a patient following admission occurs over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients).

Source and reference attributes

Submitting organisation:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Admission, version 3, DEC, NHDD, NHIMG, Superseded 01/03/2005
Metadata items which use this glossary item:	Accommodation type prior to admission code N NHIG, Standard 01/03/2005 Acute hospital and private psychiatric hospital admission labour force status code N NHIG, Standard 01/03/2005 Admission urgency status NHIG, Standard 01/03/2005 Admission urgency status code N NHIG, Standard 01/03/2005 Admitted patient NHIG, Standard 01/03/2005 Admitted patient care NMDS NHIG, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 NHIG, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006 Admitted patient hospital stay NHIG, Standard 01/03/2005 Clinical urgency code N NHIG, Standard 01/03/2005 Episode of admitted patient care—admission urgency status NHIG, Standard 01/03/2005 Episode of admitted patient care—admission urgency status, code N NHIG, Standard 01/03/2005

Episode of admitted patient care—elected accommodation status NHIG, Superseded 28/11/2006

Episode of admitted patient care—elected accommodation status, code N NHIG, Superseded 23/10/2006

Episode of admitted patient care—intended length of hospital stay NHIG, Standard 01/03/2005

Episode of admitted patient care—intended length of hospital stay, code N NHIG, Standard 01/03/2005

Episode of admitted patient care—patient election status NHIG, Standard 28/11/2006

Episode of admitted patient care—patient election status, code N NHIG, Standard 23/10/2006

Episode of care—funding eligibility indicator (Department of Veterans Affairs), code N NHIG, Standard 01/03/2005

Establishment—specialised service indicator (geriatric assessment unit), yes/no code N NHIG, Standard 01/03/2005

Non-admitted patient NHIG, Standard 01/03/2005

Non-admitted patient emergency department service episode—waiting time (to hospital admission) NHIG, Standard 01/03/2005

Non-admitted patient emergency department service episode—waiting time (to hospital admission), total hours and minutes NNNN NHIG, Standard 01/03/2005

Nursing diagnosis NHIG, Standard 01/03/2005

Patient—previous specialised treatment NHIG, Standard 01/03/2005

Patient—previous specialised treatment, code N NHIG, Standard 01/03/2005

Person—accommodation type (prior to admission), code N NHIG, Standard 01/03/2005

Person—labour force status, acute hospital and private psychiatric hospital admission code N NHIG, Standard 01/03/2005

Person—labour force status, public psychiatric hospital admission code N NHIG, Standard 01/03/2005

Person—reason for readmission following acute coronary syndrome episode NHIG, Standard 04/06/2004

Person—reason for readmission following acute coronary syndrome episode, code N[N] NHIG, Standard 04/06/2004

Previous specialised treatment code N NHIG, Standard 01/03/2005

Public psychiatric hospital admission labour force status code N NHIG, Standard 01/03/2005

Reason for readmission following acute coronary syndrome episode code N[N] NHIG, Standard 04/06/2004

Scheduled admission date NHIG, Standard 01/03/2005

Clinical intervention

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327220
Registration status:	NHIG, Standard 01/03/2005
Definition:	An intervention carried out to improve, maintain or assess the health of a person, in a clinical situation.
Context:	Health services: Information about the surgical and non-surgical interventions provides the basis for analysis of health service usage, especially in relation to specialised resources, for example theatres and equipment or human resources.

Collection and usage attributes

Comments:	Clinical interventions include invasive and non-invasive procedures, and cognitive interventions. Invasive: (a) Therapeutic interventions where there is a disruption of the epithelial lining generally, but not exclusively, with an implied closure of an incision (e.g. operations such as cholecystectomy or administration of a chemotherapeutic drug through a vascular access device); (b) Diagnostic interventions where an incision is required and/or a body cavity is entered (e.g. laparoscopy with/without biopsy, bone marrow aspiration). Non-invasive: Therapeutic or diagnostic interventions undertaken without disruption of an epithelial lining (e.g. lithotripsy, hyperbaric oxygenation; allied health interventions such as hydrotherapy; diagnostic interventions not requiring an incision or entry into a body part such as pelvic ultrasound, diagnostic imaging). Cognitive: An intervention which requires cognitive skills such as evaluating, advising, planning (e.g. dietary education, physiotherapy assessment, crisis intervention, bereavement counselling).

Source and reference attributes

Submitting organisation:	National Health Data Committee.

Relational attributes

Related metadata references:	Supersedes Clinical intervention, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005
Metadata items which use this glossary item:	Episode of admitted patient care—procedure NHIG, Standard 01/03/2005

Diagnosis

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327224
Registration status:	NHIG, Standard 01/03/2005
Definition:	A diagnosis is the decision reached, after assessment, of the nature and identity of the disease or condition of a patient or recipient of residential care (resident).
Context:	Health services: Diagnostic information provides the basis for analysis of health service usage, epidemiological studies and monitoring of specific disease entities.

Collection and usage attributes

Comments:	Classification systems which enable the allocation of a code to the diagnostic information: • International Classification of Diseases, Tenth Revision, Australian Modification (ICD-10-AM), • British Paediatric Association Classification of Diseases, • North America Nursing Diagnosis Association, • International Classification of Primary Care International, • Classification of Impairments, Disabilities and Handicaps, • International Classification of Functioning.

Source and reference attributes

Submitting organisation:	National Data Standards Committee
Origin:	

Relational attributes

Related metadata references:	Supersedes Diagnosis, version 2, DEC, NHDD, NHIMG, Superseded 01/03/2005
Metadata items which use this glossary item:	Admitted patient care NMDS NHIG, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 NHIG, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006 Person—visual acuity (left eye), code NN NHIG, Standard 01/03/2005 Person—visual acuity (right eye), code NN NHIG, Standard 01/03/2005

Episode of acute care

Identifying and definitional attributes

Metadata item type:	Glossary Item
Synonymous names:	Acute care episode for admitted patients
METeOR identifier:	327230
Registration status:	NHIG, Standard 01/03/2005
Definition:	An episode of acute care for an admitted patient is one in which the principal clinical intent is to do one or more of the following: • manage labour (obstetric), • cure illness or provide definitive treatment of injury, • perform surgery, • relieve symptoms of illness or injury (excluding palliative care), • reduce severity of illness or injury, • protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal functions, • perform diagnostic or therapeutic procedures.
Context:	Admitted patient care.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Acute care episode for admitted patients, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005
Metadata items which use this glossary item:	Admitted patient care NMDS NHIG, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 NHIG, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006

Geographic indicator

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327306
Registration status:	NCSIMG, Standard 01/03/2005
Definition:	A classification scheme that divides an area into mutually exclusive sub-areas based on geographic location. Some geographic indicators are: • Australian Standard Geographical Classification (ASGC, ABS Cat. no. 1216.0), • administrative regions, • electorates, • Accessibility/Remoteness Index of Australia (ARIA), • Rural, Remote and Metropolitan Area Classification (RRMA), and • country.
Context:	To enable the analysis of data on a geographical basis. Facilitates analysis of service provision in relation to demographic and other characteristics of the population of a geographic area.

Collection and usage attributes

Comments:	Person (address)—Australian postcode (Postcode datafile), code [NNNN] is not included in the above listing, as it is, strictly speaking, not a geographic indicator. Sometimes postcodes are used in the analysis of data on a geographical basis, which involves a conversion to Statistical Local Area (an Australian Bureau of Statistics geographical structure). This conversion results in some inaccuracy of information. However, in some data sets Person (address)—Australian postcode (Postcode datafile), code [NNNN]; is the only geographic identifier, therefore the use of other more accurate indicators (for example, conversion from address line to Statistical Local Area) is not always possible.

Source and reference attributes

Origin:	Australian Institute of Health and Welfare.

Relational attributes

Related metadata references:	Supersedes Geographic indicator, version 2, DEC, NCSDD, NCSIMG, Superseded 01/03/2005
Metadata items which use this glossary item:	Australian state/territory identifier NHIG, Standard 01/03/2005 NCSIMG, Standard 01/03/2005 NHDAMG, Standard 22/10/2005

Hospital boarder

Identifying and definitional attributes

Metadata item type:	Glossary Item
Synonymous names:	Boarder
METeOR identifier:	327242
Registration status:	NHIG, Standard 01/03/2005
Definition:	A person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care.
Context:	Admitted patient care.

Collection and usage attributes

Guide for use:	A boarder thus defined is not admitted to the hospital. However, a hospital may register a boarder. Babies in hospital at age 9 days or less cannot be boarders. They are admitted patients with each day of stay deemed to be either a qualified or unqualified day.

Source and reference attributes

Submitting organisation:	National Health Data Committee.

Relational attributes

Related metadata references:	Supersedes Hospital boarder, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005
Metadata items which use this glossary item:	Admitted patient care NMDS NHIG, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 NHIG, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006 Hospital service NHIG, Standard 01/03/2005

Hospital-in-the-home care

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327308
Registration status:	NHIG, Standard 01/03/2005
Definition:	Provision of care to hospital admitted patients in their place of residence as a substitute for hospital accommodation. Place of residence may be permanent or temporary.
Context:	Admitted patient care.

Collection and usage attributes

Comments:

The criteria for inclusion as hospital-in-the-home include but are not limited to:

- without hospital in the home care being available patients would be accommodated in the hospital,
- the treatment forms all or part of an episode of care for an admitted patient (as defined in the metadata item Admitted patient),
- the hospital medical record is maintained for the patient,
- there is adequate provision for crisis care.

Selection criteria for the assessment of suitable patients include but are not limited to:

- the hospital deems the patient requires health care professionals funded by the hospital to take an active part in their treatment,
- the patient does not require continuous 24 hour assessment, treatment or observation,
- the patient agrees to this form of treatment,
- the patient's place of residence is safe and has carer support available,
- the patient's place of residence is accessible for crisis care,
- the patient's place of residence has adequate communication facilities and access to transportation.

Source and reference attributes

Origin:	National Health Data Committee.

Relational attributes

Related metadata references:	Supersedes Hospital-in-the-home care, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005
Metadata items which use this glossary item:	Admitted patient NHIG, Standard 01/03/2005 Admitted patient care NMDS NHIG, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 NHIG, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006 Episode of admitted patient care NHIG, Standard 01/03/2005 Episode of admitted patient care—number of days of hospital-in-the-home care NHIG, Standard 01/03/2005

Episode of admitted patient care—number of days of hospital-in-the-home care, total {N[NN]} NHIG, Standard 01/03/2005

Episode of care (community setting)—first service delivery date, DDMMYYYY NHIG, Standard 01/03/2005

Number of days of hospital-in-the-home care NHIG, Standard 01/03/2005

Live birth

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327248
Registration status:	NHIG, Standard 01/03/2005
Definition:	A live birth is defined by the World Health Organization to be the complete expulsion or extraction from the mother of a baby, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of the voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born.
Context:	Perinatal Source document: *International Classification of Diseases and Related Health Problems,* 10th Revision, Vol 1, World Health Organization, 1992.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee National Perinatal Data Advisory Committee.
Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Live birth, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005
Metadata items which use this glossary item:	Admitted patient care NMDS NHIG, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 NHIG, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006 Birth event—birth plurality, code N NHIG, Standard 01/03/2005 Birth—birth weight, total grams NNNN NHIG, Standard 01/03/2005 Female—number of previous pregnancies (live birth), total NN NHIG, Standard 01/03/2005

Neonate

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327284
Registration status:	NHIG, Standard 01/03/2005
Definition:	A live birth who is less than 28 days old.
Context:	Perinatal.

Collection and usage attributes

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

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee National Perinatal Data Advisory Committee
Origin:	National Health Data Committee International Classification of Diseases and Related Health Problems, 10th Revision, WHO, 1992

Relational attributes

Related metadata references:	Supersedes Neonate, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005
Metadata items which use this glossary item:	Admitted patient care NMDS NHIG, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 NHIG, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006

Newborn qualification status

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327254
Registration status:	NHIG, Standard 01/03/2005
Definition:	Qualification status indicates whether the patient day within a newborn episode of care is either qualified or unqualified.
Context:	Admitted patient care: To provide accurate information on care provided in newborn episodes of care through exclusion of unqualified patient days.

Collection and usage attributes

Guide for use:

A newborn qualification status is assigned to each patient day within a newborn episode of care.

A newborn patient day is qualified if the infant meets at least one of the following criteria:

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

A newborn patient day is unqualified if the infant does not meet any of the above criteria.

The day on which a change in qualification status occurs is counted as a day of the new qualification status.

If there is more than one qualification status in a single day, the day is counted as a day of the final qualification status for that day.

Comments:

All babies born in hospital are admitted patients.

The newborn baby's qualified days are eligible for health insurance benefits purposes and the patient day count under the Australian Health Care Agreements. In this context, newborn qualified days are equivalent to acute days and may be denoted
as such.

The days when a newborn baby does not meet these criteria are classified as unqualified (if they are nine days old or less) and should not be counted as patient days under the Australian Health Care Agreements and are not eligible for health insurance benefit purposes.

Relational attributes

Related metadata references:	Supersedes Newborn qualification status, version 2, DEC, NHDD, NHIMG, Superseded 01/03/2005
Metadata items which use this glossary item:	Admitted patient care NMDS NHIG, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 NHIG, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006 Date of change to qualification status NHIG, Standard

01/03/2005

Episode of admitted patient care (newborn)—date of change to qualification status NHIG, Standard 01/03/2005

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

Hospital care type code N[N].N NHIG, Standard 01/03/2005

Number of qualified days NHIG, Standard 01/03/2005

Organ procurement - posthumous

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327258
Registration status:	NHIG, Standard 01/03/2005
Definition:	Organ procurement - posthumous is an activity undertaken by hospitals in which human tissue is procured for the purpose of transplantation from a donor who has been declared brain dead.
Context:	Hospital activity.

Collection and usage attributes

Comments:	This activity is not regarded as care or treatment of an admitted patient, but is registered by the hospital. Diagnoses and procedures undertaken during this activity, including mechanical ventilation and tissue procurement, are recorded in accordance with the Australian coding standards. Declarations of brain death are made in accordance with relevant state/territory legislation.

Relational attributes

Related metadata references:	Supersedes Organ procurement - posthumous, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005
Metadata items which use this glossary item:	Admitted patient care NMDS NHIG, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 NHIG, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006 Hospital service—care type NHIG, Standard 01/03/2005 Hospital service—care type, code N[N].N NHIG, Standard 01/03/2005

Resident

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327198
Registration status:	NHIG, Standard 01/03/2005
Definition:	A person who receives residential care intended to be for a minimum of one night.
Context:	Specialised mental health services (Residential mental health care).

Collection and usage attributes

Comments:	A resident in one residential mental health service cannot be concurrently a resident in another residential mental health service. A resident in a residential mental health service can be concurrently a patient admitted to a hospital.

Relational attributes

Related metadata references:	Supersedes Resident, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005
Metadata items which use this glossary item:	Admitted patient mental health care NMDS NHIG, Superseded 07/12/2005 Admitted patient mental health care NMDS NHIG, Superseded 23/10/2006 Admitted patient mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006 Community mental health care NMDS 2005-2006 NHIG, Superseded 07/12/2005 Episode of care—mental health legal status, code N NHIG, Standard 01/03/2005 Episode of care—number of psychiatric care days NHIG, Standard 01/03/2005 Episode of care—number of psychiatric care days, total N[NNNN] NHIG, Standard 01/03/2005 Episode of residential care NHIG, Standard 01/03/2005 Episode of residential care (mental health care)—referral destination, code N NHIG, Standard 01/03/2005 Episode of residential care—episode end date NHIG, Standard 01/03/2005 Episode of residential care—episode end date, DDMMYYYY NHIG, Standard 01/03/2005 Episode of residential care—episode start date NHIG, Standard 01/03/2005 Episode of residential care—episode start date, DDMMYYYY NHIG, Standard 01/03/2005 Episode of residential care—number of leave days, total N[NN] NHIG, Standard 01/03/2005 Episode of residential care—referral destination (mental health care) NHIG, Standard 01/03/2005 Establishment—number of available beds for admitted patients/residents NHIG, Standard 01/03/2005 Establishment—number of available beds for admitted

patients/residents, average N[NNN] NHIG, Standard 01/03/2005

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

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

Residential mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

Residential stay—episode start date NHIG, Standard 01/03/2005

Residential stay—episode start date, DDMMYYYY NHIG, Standard 01/03/2005

Residential mental health care service

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327280

Registration status: NHIG, Standard 01/03/2005

Definition: A residential mental health service is a specialised mental health service that:

- employs mental health-trained staff on-site;
- provides rehabilitation, treatment or extended care:
  to residents provided with care intended to be on an overnight basis;
  in a domestic-like environment; and
- encourages the resident to take responsibility for their daily living activities.

These services include those that employ mental health trained staff on-site 24 hours per day and other services with less intensive staffing. However all these services employ on-site mental health trained staff for some part of each day.

Context: Specialised residential mental health services.

Relational attributes

Related metadata references: Supersedes Residential mental health service, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005

Metadata items which use this glossary item:

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

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

Admitted patient mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

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

Episode of care—mental health legal status, code N NHIG, Standard 01/03/2005

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

Mental health establishments NMDS 2005-2006 NHIG, Superseded 21/03/2006

Mental health establishments NMDS 2006-2007 NHIG, Superseded 23/10/2006

Mental health establishments NMDS 2007-2008 NHIG, Standard 23/10/2006

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

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

Residential mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

Specialised mental health service setting code N NHIG, Superseded 08/12/2004

Specialised mental health service setting code N NHIG,

Same-day patient

Identifying and definitional attributes

Metadata item type: Glossary Item

METeOR identifier: 327270

Registration status: NHIG, Standard 01/03/2005

Definition: A same-day patient is a patient who is admitted and separates on the same date, and who meets one of the following minimum criteria:

- that the patient receive same-day surgical and diagnostic services as specified in bands 1A, 1B, 2, 3, and 4 but excluding uncertified type C Professional Attention Procedures within the Health Insurance Basic Table as defined in s.4 (1) of the *National Health Act 1953* (Commonwealth),
- that the patient receive type C Professional Attention Procedures as specified in the Health Insurance Basic Table as defined in s.4 (1) of the *National Health Act 1953* (Commonwealth) with accompanying certification from a medical practitioner that an admission was necessary on the grounds of the medical condition of the patient or other special circumstances that relate to the patient.

Context: Admitted patient care.

Collection and usage attributes

Comments: Same-day patients may be either intended to be separated on the same day, or intended overnight-stay patients who left of their own accord, died or were transferred on their first day in the hospital.

Treatment provided to an intended same-day patient who is subsequently classified as an overnight-stay patient shall be regarded as part of the overnight episode.

Non-admitted (emergency or outpatient) services provided to a patient who is subsequently classified as an admitted patient shall be regarded as part of the admitted episode. Any occasion of service should be recorded and identified as part of the admitted patient's episode of care.

Data on same-day patients are derived by a review of admission and separation dates.

Source and reference attributes

Origin:

National Health Data Committee

Relational attributes

Related metadata references: Supersedes Same-day patient, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005

Metadata items which use this glossary item: Admitted patient care NMDS NHIG, Superseded 07/12/2005

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

Admitted patient care NMDS 2007-2008 NHIG, Standard

23/10/2006

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

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

Admitted patient mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

Episode of admitted patient care—intended length of hospital stay NHIG, Standard 01/03/2005

Episode of admitted patient care—length of stay (excluding leave days) NHIG, Standard 01/03/2005

Episode of admitted patient care—length of stay (including leave days), total N[NN] NHIG, Standard 01/03/2005

Episode of admitted patient care—number of leave days, total N[NN] NHIG, Standard 01/03/2005

Establishment—number of patient days, total N[N(7)] NHIG, Standard 01/03/2005

Separation

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327268
Registration status:	NHIG, Standard 01/03/2005
Definition:	Separation is the process by which an episode of care for an admitted patient ceases. A separation may be formal or statistical. Formal separation: The administrative process by which a hospital records the cessation of treatment and/or care and/or accommodation of a patient. Statistical separation: The administrative process by which a hospital records the cessation of an episode of care for a patient within the one hospital stay.
Context:	Admitted patient care.

Collection and usage attributes

Comments:	This treatment and/or care provided to a patient prior to separation occurs over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients). While this concept is also applicable to non-Admitted patient care and welfare services, different terminology to 'separation' is often used in these other care settings.

Source and reference attributes

Submitting organisation:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Separation, version 3, DEC, NHDD, NHIMG, Superseded 01/03/2005
Metadata items which use this glossary item:	Admitted patient care NMDS NHIG, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 NHIG, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006 Admitted patient hospital stay NHIG, Standard 01/03/2005 Admitted patient mental health care NMDS NHIG, Superseded 23/10/2006 Admitted patient mental health care NMDS NHIG, Superseded 07/12/2005 Admitted patient mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006 Community mental health care NMDS 2005-2006 NHIG, Superseded 07/12/2005 Episode of admitted patient care NHIG, Standard 01/03/2005 Episode of admitted patient care—number of leave days NHIG, Standard 01/03/2005

Episode of admitted patient care—number of leave periods, total N[N] NHIG, Standard 01/03/2005

Episode of admitted patient care—separation date, DDMMYYYY NHIG, Standard 01/03/2005

Episode of admitted patient care—separation mode NHIG, Standard 01/03/2005

Episode of admitted patient care—separation mode, code N NHIG, Standard 01/03/2005

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

Episode of care—principal diagnosis, code (ICD-10-AM 4th edn) ANN{.N[N]} NHIG, Superseded 07/12/2005

Episode of care—principal diagnosis, code (ICD-10-AM 5th edn) ANN{.N[N]} NHIG, Standard 07/12/2005

Establishment—number of individual session occasions of service for non-admitted patients (alcohol and drug), total N[NNNNNN] NHIG, Standard 01/03/2005

Establishment—number of individual session occasions of service for non-admitted patients (community health services), total N[NNNNNN] NHIG, Standard 01/03/2005

Establishment—number of individual session occasions of service for non-admitted patients (district nursing services), total N[NNNNNN] NHIG, Standard 01/03/2005

Establishment—number of individual session occasions of service for non-admitted patients (emergency services), total N[NNNNNN] NHIG, Standard 01/03/2005

Establishment—number of individual session occasions of service for non-admitted patients (endoscopy and related procedures), total N[NNNNNN] NHIG, Standard 01/03/2005

Establishment—number of individual session occasions of service for non-admitted patients (mental health), total N[NNNNNN] NHIG, Standard 01/03/2005

Establishment—number of individual session occasions of service for non-admitted patients (other medical/surgical/diagnostic), total N[NNNNNN] NHIG, Standard 01/03/2005

Establishment—number of individual session occasions of service for non-admitted patients (other outreach services), total N[NNNNNN] NHIG, Standard 01/03/2005

Establishment—number of individual session occasions of service for non-admitted patients (pathology), total N[NNNNNN] NHIG, Standard 01/03/2005

Establishment—number of individual session occasions of service for non-admitted patients (pharmacy), total N[NNNNNN] NHIG, Standard 01/03/2005

Establishment—number of separations NHIG, Standard 01/03/2005

Establishment—number of separations (financial year), total N[NNNNN] NHIG, Standard 01/03/2005

Person—congenital malformation NHIG, Standard 01/03/2005

Person—congenital malformation, code (BPA 1979) ANN.N[N] NHIG, Standard 01/03/2005

Person—congenital malformation, code (ICD-10-AM 3rd edn) ANN{.N[N]} NHIG, Superseded 28/06/2004

Person—congenital malformation, code (ICD-10-AM 4th edn)

ANN{.N[N]} NHIG, Superseded 07/12/2005

Person—congenital malformation, code (ICD-10-AM 5th edn) ANN{.N[N]} NHIG, Standard 07/12/2005

Separation mode NHIG, Standard 01/03/2005

Separation mode code N NHIG, Standard 01/03/2005