Acute coronary syndrome (clinical) DSS

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List of metadata items

Data Element Short Names 7
Metadata items 10
Acute coronary syndrome (clinical) DSS 11
Acute coronary syndrome clinical event cluster 17
Acute coronary syndrome pharmacotherapy data cluster 18
Coronary artery cluster 20
Electrocardiogram cluster 22
Functional stress test cluster 23
Ventricular ejection fraction cluster 24
Electrocardiogram — electrocardiogram date, DDMMYYYY 25
Electrocardiogram — electrocardiogram time, hhmm 26
Electrocardiogram — ST-segment-elevation in lead V4R indicator, yes/no code N 27
Electrocardiogram — bundle-branch block status, code N 29
Electrocardiogram — change location, code N 30
Electrocardiogram — change type, code N 32
Electrocardiogram — heart rhythm type, code N[N] 34
Electrocardiogram — lead V4R presence indicator, yes/no code N 36
Electrocardiogram — new Q waves indicator, yes/no code N 37
Episode of admitted patient care — admission date, DDMMYYYY 39
Episode of admitted patient care — admission time, hhmm 41
Episode of admitted patient care — separation date, DDMMYYYY 42
Episode of admitted patient care — separation mode, code N 44
Episode of care — principal diagnosis, code (ICD-10-AM 6th edn) ANN{.N[N]} 46
Episode of care — principal source of funding, hospital code NN 48
Establishment — organisation identifier (Australian), NNX[X]NNNNN 51
Functional stress test — stress test intensity, code N 54
Functional stress test — assessment of cardiac perfusion, code N[N] 56
Functional stress test — ischaemic and perfusion outcome result, code N 57
Functional stress test — stress test element, code N 59
Functional stress test — test date, DDMMYYYY 60
Health service event — presentation date, DDMMYYYY 61
Health service event — presentation time, hhmm 63
Health service event — referral to rehabilitation service date, DDMMYYYY 65
Laboratory standard — upper limit of normal range for creatine kinase isoenzyme, total units per litre N[NNN] 67
Laboratory standard — upper limit of normal range for creatine kinase myocardial band isoenzyme, total micrograms per litre N[NNN] 68
Laboratory standard — upper limit of normal range for creatine kinase myocardial band isoenzyme, total units per litre N[NNN] 69
Laboratory standard — upper limit of normal range for troponin assay, total micrograms per litre N[NNN] 70
Laboratory standard — upper limit of normal range of glycosylated haemoglobin, percentage N[N].N 71
Non-admitted patient emergency department service episode — transport mode (arrival), code N 73
Non-admitted patient emergency department service episode — triage category, code N 75
Non-admitted patient emergency department service episode — triage date, DDMMYYYY 77
Non-admitted patient emergency department service episode — triage time, hhmm 78
Non-admitted patient emergency department service episode — type of visit to emergency department, code N 80

Person with acute coronary syndrome—acute coronary syndrome related clinical event date, DDMMYYYY 82
Person with acute coronary syndrome—acute coronary syndrome related clinical event time, hhmm 83
Person with acute coronary syndrome—bleeding location, instrumented code N(N) 84
Person with acute coronary syndrome—bleeding location, non-instrumented code N(N) 86
Person with acute coronary syndrome—lifestyle counselling type, code N 88
Person with acute coronary syndrome—pharmacotherapy type prescribed in hospital, code N[N] 90
Person with acute coronary syndrome—pharmacotherapy type taken post discharge from hospital, code N[N] 92
Person with acute coronary syndrome—type of acute coronary syndrome related clinical event experienced, code N[N] 94
Person with acute coronary syndrome—underlying cause of acute coronary syndrome, code N 98
Person—acute coronary syndrome procedure type, code NN 99
Person—acute coronary syndrome related medical history, code NN 102
Person—acute coronary syndrome risk stratum, code N 105
Person—acute coronary syndrome symptoms onset date, DDMMYYYY 108
Person—acute coronary syndrome symptoms onset time, hhmm 109
Person—angina episodes count (24 hours preceding hospital presentation), total number NN[N] 111
Person—angina status, Canadian Cardiovascular Society code N 112
Person—bleeding episode status, Thrombolysis in Myocardial Infraction (TIMI) code N 114
Person—C-reactive protein level (measured), total milligrams per litre N[NN].N 116
Person—C-reactive protein level measured date, DDMMYYYY 118
Person—C-reactive protein level measured time, hhmm 119
Person—chest pain pattern, code N 120
Person—cholesterol level (measured), total millimoles per litre N[N].N 122
Person—clinical evidence status (acute coronary syndrome related medical history), yes/no code N 124
Person—clinical procedure timing, code N 127
Person—coronary artery bypass graft date, DDMMYYYY 128
Person—coronary artery bypass graft location, code N 129
Person—coronary artery stenosis location, code N 130
Person—count of coronary artery lesions attempted, total number N[N] 131
Person—count of coronary artery lesions successfully dilated, total number N[N] 132
Person—count of coronary artery stents, total number N[N] 133
Person—country of birth, code (SACC 2008) NNNN 134
Person—creatine kinase isoenzyme level (measured), total units per litre N[NNN] 136
Person—creatine kinase myocardial band isoenzyme measured date, DDMMYYYY 138
Person—creatine kinase myocardial band isoenzyme measured time, hhmm 139
Person—creatine kinase-myocardial band isoenzyme level (measured), total micrograms per litre N[NNN] 141
Person—creatine kinase-myocardial band isoenzyme level (measured), total units per litre N[NNN] 142
Person—creatinine serum level measured date, DDMMYYYY 144
Person—creatinine serum level, total micromoles per litre NN[NN] 145
Person—date of birth, DDMMYYYY 147
Person—date of death, DDMMYYYY 152
Person—diabetes mellitus status, code NN 154
Person—diabetes therapy type, code NN 157

Person—diagnostic cardiac catheterisation date, DDMMYYYY 159
Person—diagnostic cardiac catheterisation time, hhmm 160
Person—dyslipidaemia treatment with anti-lipid medication indicator (current), code N 161
Person—electrocardiogram Q waves indicator, yes/no code N 163
Person—fibrinolytic drug administered, code N 165
Person—functional stress test performed indicator, yes/no code N 166
Person—glycosylated haemoglobin level (measured), percentage N[N].N 167
Person—height (measured), total centimetres NN[N].N 169
Person—high-density lipoprotein cholesterol level (measured), total millimoles per litre [N].NN 173
Person—hypertension treatment with antihypertensive medication indicator (current), code N175
Person—implantable cardiac defibrillator procedure date, DDMMYYYY 177
Person—implantable cardiac defibrillator procedure time, hhmm 178
Person—Indigenous status, code N 179
Person—intra-aortic balloon pump procedure date, DDMMYYYY 184
Person—intra-aortic balloon pump procedure time, hhmm 185
Person—intravenous fibrinolytic therapy date, DDMMYYYY 186
Person—intravenous fibrinolytic therapy time, hhmm 187
Person—Killip classification, code N 188
Person—low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N 190
Person—maximum stenosis coronary artery, percentage N[NN] 192
Person—most recent stroke date, DDMMYYYY 193
Person—non-invasive ventilation administration date, DDMMYYYY 194
Person—non-invasive ventilation administration time, hhmm 195
Person—pacemaker insertion date, DDMMYYYY 196
Person—pacemaker insertion time, hhmm 197
Person—percutaneous coronary intervention procedure type, code N 198
Person—person identifier, XXXXXX[X(14)] 200
Person—premature cardiovascular disease family history status, code N 203
Person—primary percutaneous coronary intervention date, DDMMYYYY 205
Person—primary percutaneous coronary intervention time, hhmm 206
Person—reason for non prescription of pharmacotherapy, code N 207
Person—reason for readmission following acute coronary syndrome episode, code N[N] 208
Person—rescue percutaneous coronary intervention date, DDMMYYYY 211
Person—rescue percutaneous coronary intervention time, hhmm 212
Person—revascularisation percutaneous coronary intervention date, DDMMYYYY 213
Person—revascularisation percutaneous coronary intervention time, hhmm 214
Person—sex, code N 216
Person—timing of ACE-inhibitor prescription, code N 221
Person—timing of angiotensin II receptor blocker prescription, code N 223
Person—timing of antithrombin therapy prescription, code N 225
Person—timing of aspirin prescription, code N 227
Person—timing of beta-blocker prescription, code N 229
Person—timing of clopidogrel prescription, code N 231
Person—timing of glycoprotein IIb/IIIa inhibitor prescription, code N 233
Person—timing of statin prescription, code N 235
Person—tobacco smoking status, code N 237
Person—triglyceride level (measured), total millimoles per litre N[N].N 240
Person—troponin assay type, code N 242

Person—troponin level (measured), total micrograms per litre NN.NN 243
Person—troponin level measured date, DDMMYYYY 245
Person—troponin level measured time, hhmm 246
Person—underlying cause of death, code (ICD-10 2nd edn) ANN-ANN 247
Person—units of blood transfused, total N[NNN] 249
Person—vascular condition status (history), code NN 250
Person—ventricular ejection fraction test performed indicator, yes/no code N 252
Person—weight (measured), total kilograms N[NN].N 253
Ventricular ejection fraction test—test date, DDMMYYYY 257
Ventricular ejection fraction test—test time, hhmm 258
Ventricular ejection fraction test—test type, code N 259
Ventricular ejection fraction—test result, code N 260
Ventricular ejection fraction—test result, percentage N[N].N 262

Data Element Short Names

Acute coronary syndrome related clinical event type 94
Acute coronary syndrome related medical history 102
Acute coronary syndrome stratum 105
Admission date 39
Admission time 41
Angina status 112
Bleeding episode using TIMI criteria (status) 114
Bundle-branch block status 29
Chest pain pattern category 120
Cholesterol—HDL (measured) 173
Cholesterol—LDL (calculated) 190
Cholesterol—total (measured) 122
Clinical evidence of acute coronary syndrome related medical history 124
Clinical procedure timing (status) 127
Coronary artery bypass graft location 129
Coronary artery stenosis location 130
Country of birth 134
C-reactive protein level (measured) 116
Creatine kinase isoenzyme—upper limit of normal range (U/L) 67
Creatine kinase level (U/L) 136
Creatine kinase MB isoenzyme level (micrograms per litre) 141
Creatine kinase MB isoenzyme level (units per litre) 142
Creatine kinase MB isoenzyme—upper limit of normal range (units per litre) 69
Creatine kinase MB isoenzyme—upper limit of normal range (micrograms per litre) 68
Creatinine serum level (measured) 145
Date C-reactive protein level measured 118
Date creatine kinase MB isoenzyme measured 138
Date creatinine serum level measured 144
Date of acute coronary syndrome related clinical event 82
Date of birth 147
Date of coronary artery bypass graft 128
Date of death 152
Date of diagnostic cardiac catheterisation 159
Date of electrocardiogram 25
Date of functional stress test 60
Date of implantable cardiac defibrillator procedure 177
Date of intra-aortic balloon pump procedure 184
Date of intravenous fibrinolytic therapy 186
Date of most recent stroke 193
Date of non-invasive ventilation administration 194
Date of onset of acute coronary syndrome symptoms 108
Date of pacemaker insertion 196
Date of primary percutaneous coronary intervention 205
Date of referral to rehabilitation 65
Date of rescue percutaneous coronary intervention 211
Date of revascularisation percutaneous coronary intervention 213
Date of triage 77
Date of ventricular ejection fraction test 257
Date patient presents 61

Date troponin measured 245
Diabetes status 154
Diabetes therapy type 157
Dyslipidaemia treatment indicator 161
ECG - Q waves indicator 163
Electrocardiogram - new Q waves indicator 37
Electrocardiogram - lead V4R presence indicator 36
Electrocardiogram - ST-segment-elevation in lead V4R 27
Electrocardiogram change location 30
Electrocardiogram change type 32
Emergency department arrival mode - transport 73
Establishment identifier 51
Fibrinolytic drug used 165
Functional stress ischaemic and perfusion outcome result 57
Functional stress test assessment of cardiac perfusion 56
Functional stress test element 59
Functional stress test intensity 54
Functional stress test performed indicator 166
Funding source for hospital patient 48
Glycosylated haemoglobin level (measured) 167
Glycosylated Haemoglobin—upper limit of normal range (percentage) 71
Heart rhythm type 34
Height (measured) 169
Hypertension - treatment 175
Indigenous status 179
Instrumented bleeding location 84
Killip classification code 188
Lifestyle counselling type 88
Maximum stenosis coronary artery 192
Mode of separation 44
Non-instrumented bleeding location 86
Number of coronary artery lesions attempted 131
Number of coronary artery lesions successfully dilated 132
Number of coronary artery stents 133
Number of episodes of angina in last 24 hours 111
Other/Underlying cause of acute coronary syndrome 98
Percutaneous coronary intervention procedure type 198
Person identifier 200
Pharmacotherapy type prescribed for acute coronary syndrome in hospital 90
Pharmacotherapy type taken for acute coronary syndrome post discharge 92
Premature cardiovascular disease family history (status) 203
Principal diagnosis 46
Reason for non prescription of pharmacotherapy 207
Reason for readmission—acute coronary syndrome 208
Separation date 42
Sex 216
Time C-reactive protein level measured 119
Time creatine kinase MB isoenzyme measured 139
Time of acute coronary syndrome related clinical event 83
Time of diagnostic cardiac catheterisation 160

Time of electrocardiogram 26
Time of implantable cardiac defibrillator procedure 178
Time of intra-aortic balloon pump procedure 185
Time of intravenous fibrinolytic therapy 187
Time of non-invasive ventilation administration 195
Time of onset of acute coronary syndrome symptoms 109
Time of pacemaker insertion 197
Time of primary percutaneous coronary intervention 206
Time of rescue percutaneous coronary intervention 212
Time of revascularisation percutaneous coronary intervention 214
Time of triage 78
Time of ventricular ejection fraction test 258
Time patient presents 63
Time troponin measured 246
Timing of ACE-inhibitor prescription 221
Timing of angiotensin II receptor blocker prescription 223
Timing of antithrombin therapy prescription 225
Timing of aspirin prescription 227
Timing of beta-blocker prescription 229
Timing of clopidogrel prescription 231
Timing of glycoprotein IIb/IIIa inhibitor prescription 233
Timing of statin prescription 235
Tobacco smoking status 237
Total blood units transfused 249
Triage category 75
Triglyceride level (measured) 240
Troponin assay type 242
Troponin assay—upper limit of normal range (micrograms per litre) 70
Troponin level (measured) 243
Type of visit to emergency department 80
Underlying cause of death 247
Vascular history 250
Ventricular ejection fraction measurement indicator 252
Ventricular ejection fraction test result (percentage) 262
Ventricular ejection fraction test result (code) 260
Ventricular ejection fraction test type 259
Weight in kilograms (measured) 253

Metadata items

Acute coronary syndrome (clinical) DSS

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	372930
Registration status:	Health, Standard 01/10/2008
DSS type:	Data Set Specification (DSS)
Scope:	This Acute Coronary Syndrome (ACS) data set specification is not mandated for collection but is recommended as best practice if ACS data are to be collected. This data set specification enables individual hospitals or health service areas to develop collection methods and policies appropriate for their service. The scope for the ACS data set specification is to collect data on the period between when a person with ACS symptoms was first referred to a hospital or directly presented at a hospital, and when a person leaves the hospital, either from the emergency department or is discharged from the hospital. Some of the data relevant to the management of patients attending hospital with ACS symptoms is specified for collection at follow-up visits with a specialist or as a non-admitted patient. Acute coronary syndromes reflect the spectrum of coronary artery disease resulting in acute myocardial ischaemia, and span unstable angina, non-ST segment elevation myocardial infarction (NSTEMI) and ST-segment elevation myocardial infarction (STEMI). Clinically these diagnoses encompass a wide variation in risk, require complex and time urgent risk stratification and represent a large social and economic burden. The definitions used in this data set specification are designed to underpin the data collected by health professionals in their day-to-day acute care practice. They relate to the realities of an acute clinical consultation for patients presenting with chest pain/ discomfort and the need to correctly identify, evaluate and manage patients at increased risk of a coronary event. The data elements specified in this metadata set provide a framework for: • promoting the delivery of evidenced-based acute coronary syndrome management care to patients; • facilitating the ongoing improvement in the quality and safety of acute coronary syndrome management in acute care settings in Australia and New Zealand; • improving the epidemiological and public health understanding of this syndrome; and • supporting acute care services as they develop information systems to complement the above. This is particularly important as the scientific evidence supporting the development of the data elements within the ACS data set specification indicate that accurate identification of the evolving myocardial infarction patient or the high/intermediate risk patient leading to the implementation of the appropriate management pathway impacts on the patient's outcome. Having a nationally recognised set of definitions in relation to defining a patient's diagnosis, risk status and

outcomes is a prerequisite to achieving the above aims.

The ACS data set specification is based on the American College of Cardiology (ACC) Data Set for Acute Coronary Syndrome as published in the Journal of the American College of Cardiology in December 2001 (38:2114-30) as well as more recent scientific evidence around the diagnosis of myocardial infarction presented in the National Heart Foundation of Australia/Cardiac Society of Australia and New Zealand Guidelines for the management of acute coronary syndromes (MJA 2006;184;S1-S32). The data elements are alphabetically listed and grouped in a similar manner to the American College of Cardiology's data set format. These features of the Australian ACS data set should ensure that the data is internationally comparable.

Many of the data elements in this data set specification may also be used in the collection of other cardiovascular clinical information.

Where appropriate, it may be useful if the data definitions in this data set specification were also used to address data definition needs in non-clinical environments such as public health surveys etc. This could allow for qualitative comparisons between data collected in, and aggregated from, clinical settings (i.e. using application of the ACS data set specification), with that collected through other means (e.g. public health surveys, reports).

A set of ACS data elements and standardised definitions can inform the development and conduct of future registries at both the national and local level.

The working group formed under the National Heart Foundation of Australia (Heart Foundation) and the Cardiac Society of Australia and New Zealand (CSANZ) initiative was diverse and included representation from the following organisations: the Heart Foundation, the CSANZ, the Australasian College of Emergency Medicine, the Australian Institute of Health and Welfare, the Australasian Society of Cardiac & Thoracic Surgeons, Royal Australian College of Physicians (RACP), RACP - Towards a Safer Culture, National Centre for Classification in Health (Brisbane), the NSW Aboriginal Health & Medical Research Council, the George Institute for International Health, the School of Population Health at the University of Western Australia and the National Cardiovascular Monitoring System Advisory Committee.

To ensure the broad acceptance of the data set specification, the working group also sought consultation from the heads of cardiology departments, other specialist professional bodies and regional key opinion leaders in the field of acute coronary syndromes.

Collection and usage attributes

Guide for use:

There are six data clusters in the Acute Coronary Syndrome (Clinical) DSS. To ensure a complete description of the clinical management of acute coronary syndromes (ACS) it is recommended that all clusters be collected along with the individual data elements during the current ACS event by the individual hospital or health service area.

The six data clusters in this DSS include:

1. Acute coronary syndrome clinical event cluster
2. Functional stress test cluster
3. Electrocardiogram cluster
4. Ventricular ejection fraction cluster
5. Acute coronary syndrome pharmacotherapy cluster
6. Coronary artery cluster

Collection methods: This data set specification is primarily concerned with the clinical use of ACS-Data. Acute care environments such as hospital emergency departments, coronary care units or similar acute care areas are the settings in which implementation of the core ACS data set specification should be considered. A wider range of health and health related establishments that create, use or maintain, records on health care clients, could also use it.

Relational attributes

Related metadata references: Supersedes Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Acute coronary syndrome clinical event cluster	Conditional	1
-	Acute coronary syndrome pharmacotherapy data cluster	Optional	1
-	Coronary artery cluster	Optional	1
-	Electrocardiogram cluster	Optional	1
-	Functional stress test cluster	Optional	1
-	Ventricular ejection fraction cluster	Conditional	1
-	Episode of admitted patient care—admission date, DDMMYYYY	Optional	1
-	Episode of admitted patient care—admission time, hhmm	Optional	1
-	Episode of admitted patient care—separation date, DDMMYYYY	Optional	1
-	Episode of admitted patient care—separation mode, code N	Optional	1
-	Episode of care—principal diagnosis, code (ICD-10-AM 6th edn) ANN{.N[N]}	Optional	1
-	Episode of care—principal source of funding, hospital code NN	Optional	1
-	Establishment—organisation identifier (Australian), NNX[X]NNNNN	Optional	1
-	Health service event—presentation date, DDMMYYYY	Optional	1
-	Health service event—presentation time, hhmm	Optional	1
-	Health service event—referral to rehabilitation service date, DDMMYYYY	Optional	1
-	Laboratory standard—upper limit of normal range for creatine kinase isoenzyme, total units per litre N[NNN]	Optional	1
-	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total micrograms per litre N[NNN]	Conditional	1
-	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total units per litre N[NNN]	Conditional	1
-	Laboratory standard—upper limit of normal range for troponin assay, total micrograms per litre N[NNN]	Conditional	1

-	Laboratory standard—upper limit of normal range of glycosylated haemoglobin, percentage N[N].N	Conditional	1
-	Non-admitted patient emergency department service episode—transport mode (arrival), code N	Optional	1
-	Non-admitted patient emergency department service episode—triage category, code N	Conditional	1
-	Non-admitted patient emergency department service episode—triage date, DDMMYYYY	Optional	1
-	Non-admitted patient emergency department service episode—triage time, hhmm	Optional	1
-	Non-admitted patient emergency department service episode—type of visit to emergency department, code N	Optional	1
-	Person with acute coronary syndrome—bleeding location, instrumented code N(N)	Optional	1
-	Person with acute coronary syndrome—bleeding location, non-instrumented code N(N)	Optional	1
-	Person with acute coronary syndrome—lifestyle counselling type, code N	Optional	1
-	Person with acute coronary syndrome—underlying cause of acute coronary syndrome, code N	Optional	1
-	Person—acute coronary syndrome procedure type, code NN	Optional	1
-	Person—acute coronary syndrome related medical history, code NN	Optional	1
-	Person—acute coronary syndrome risk stratum, code N	Optional	1
-	Person—acute coronary syndrome symptoms onset date, DDMMYYYY	Optional	1
-	Person—acute coronary syndrome symptoms onset time, hhmm	Optional	1
-	Person—angina episodes count (24 hours preceding hospital presentation), total number NN[N]	Conditional	1
-	Person—angina status, Canadian Cardiovascular Society code N	Optional	1
-	Person—bleeding episode status, Thrombolysis in Myocardial Infraction (TIMI) code N	Optional	1
-	Person—C-reactive protein level (measured), total milligrams per litre N[NN].N	Optional	1
-	Person—C-reactive protein level measured date, DDMMYYYY	Optional	1
-	Person—C-reactive protein level measured time, hhmm	Optional	1
-	Person—chest pain pattern, code N	Optional	1
-	Person—cholesterol level (measured), total millimoles per litre N[N].N	Optional	1
-	Person—clinical evidence status (acute coronary syndrome related medical history), yes/no code N	Optional	1
-	Person—clinical procedure timing, code N	Optional	1
-	Person—country of birth, code (SACC 2008) NNNN	Optional	1
-	Person—creatine kinase isoenzyme level (measured), total units per litre N[NNN]	Conditional	1
-	Person—creatine kinase myocardial band isoenzyme measured date, DDMMYYYY	Conditional	1
-	Person—creatine kinase myocardial band isoenzyme measured time, hhmm	Conditional	1

-	Person—creatine kinase-myocardial band isoenzyme level (measured), total micrograms per litre N[NNN]	Conditional	1
-	Person—creatine kinase-myocardial band isoenzyme level (measured), total units per litre N[NNN]	Conditional	1
-	Person—creatinine serum level measured date, DDMMYYYY	Conditional	1
-	Person—creatinine serum level, total micromoles per litre NN[NN]	Conditional	1
-	Person—date of birth, DDMMYYYY	Optional	1
-	Person—date of death, DDMMYYYY	Optional	1
-	Person—diabetes mellitus status, code NN	Conditional	1
-	Person—diabetes therapy type, code NN	Conditional	1
-	Person—diagnostic cardiac catheterisation date, DDMMYYYY	Conditional	1
-	Person—diagnostic cardiac catheterisation time, hhmm	Conditional	1
-	Person—dyslipidaemia treatment with anti-lipid medication indicator (current), code N	Conditional	1
-	Person—glycosylated haemoglobin level (measured), percentage N[N].N	Optional	1
-	Person—height (measured), total centimetres NN[N].N	Conditional	1
-	Person—high-density lipoprotein cholesterol level (measured), total millimoles per litre [N].NN	Optional	1
-	Person—hypertension treatment with antihypertensive medication indicator (current), code N	Optional	1
-	Person—implantable cardiac defibrillator procedure date, DDMMYYYY	Optional	1
-	Person—implantable cardiac defibrillator procedure time, hhmm	Optional	1
-	Person—Indigenous status, code N	Optional	1
-	Person—intra-aortic balloon pump procedure date, DDMMYYYY	Conditional	1
-	Person—intra-aortic balloon pump procedure time, hhmm	Conditional	1
-	Person—Killip classification, code N	Optional	1
-	Person—low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N	Conditional	1
-	Person—most recent stroke date, DDMMYYYY	Conditional	1
-	Person—non-invasive ventilation administration date, DDMMYYYY	Conditional	1
-	Person—non-invasive ventilation administration time, hhmm	Optional	1
-	Person—pacemaker insertion date, DDMMYYYY	Optional	1
-	Person—pacemaker insertion time, hhmm	Conditional	1
-	Person—person identifier, XXXXXX[X(14)]	Optional	1
-	Person—premature cardiovascular disease family history status, code N	Optional	1
-	Person—reason for readmission following acute coronary syndrome episode, code N[N]	Optional	1
-	Person—sex, code N	Optional	1
-	Person—tobacco smoking status, code N	Optional	1
-	Person—triglyceride level (measured), total millimoles per litre N[N].N	Optional	1

-	Person—troponin assay type, code N	Optional	1
-	Person—troponin level (measured), total micrograms per litre NN.NN	Optional	1
-	Person—troponin level measured date, DDMMYYYY	Optional	1
-	Person—troponin level measured time, hhmm	Optional	1
-	Person—underlying cause of death, code (ICD-10 2nd edn) ANN-ANN	Optional	1
-	Person—units of blood transfused, total N[NNN]	Conditional	1
-	Person—vascular condition status (history), code NN	Conditional	1
-	Person—weight (measured), total kilograms N[NN].N	Conditional	1

Acute coronary syndrome clinical event cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	352671
Registration status:	Health, Standard 01/10/2008
DSS type:	Data Set Specification (DSS)
Scope:	The acute coronary syndrome (ACS) related clinical events are those which can negatively impact on the outcomes of a person with ACS. Information on the occurrence of these events in people with ACS is required due to an emerging appreciation of their relationship with late mortality. The clinical event cluster collects information on the timing and type of clinical events experienced during the current hospitalisation.

Source and reference attributes

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

Relational attributes

Implementation in Data Set Specification:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Person with acute coronary syndrome—acute coronary syndrome related clinical event date, DDMMYYYY	Conditional	15
-	Person with acute coronary syndrome—acute coronary syndrome related clinical event time, hhmm	Conditional	1
-	Person with acute coronary syndrome—type of acute coronary syndrome related clinical event experienced, code N[N]	Conditional	15

Acute coronary syndrome pharmacotherapy data cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	351876
Registration status:	Health, Standard 01/10/2008
DSS type:	Data Set Specification (DSS)
Scope:	The pharmacotherapies collected in this data cluster are recommended for the management of acute coronary syndromes (ACS) in the national guidelines. The following pharmacotherapies are collected as part of this data cluster: • Aspirin • Angiotensin converting enzyme (ACE) inhibitor • Angiotensin II receptor blocker • Antithrombin • Beta-blocker • Clopidogrel • Fibrinolytic • Glycoprotein IIb/IIIa receptor antagonist • Statin The pharmacotherapy cluster collects information on the type of pharmacotherapies prescribed and the timing of each prescription.

Source and reference attributes

Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand
Reference documents:	National Heart Foundation of Australia & Cardiac Society of Australia and New Zealand. Guidelines for the management of acute coronary syndromes 2006. Med J Aust 2006; 184; S1-S32. © MJA 2006

Relational attributes

Implementation in Data Set Specification:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Person with acute coronary syndrome—pharmacotherapy type prescribed in hospital, code N[N]	Mandatory	10
-	Person with acute coronary syndrome—pharmacotherapy type taken post discharge from hospital, code N[N]	Mandatory	7
-	Person—fibrinolytic drug administered, code N	Conditional	1
-	Person—intravenous fibrinolytic therapy date, DDMMYYYY	Conditional	1
-	Person—intravenous fibrinolytic therapy time, hhmm	Conditional	1
-	Person—reason for non prescription of pharmacotherapy, code N	Conditional	9
-	Person—timing of ACE-inhibitor prescription, code N	Conditional	5

-	Person—timing of angiotensin II receptor blocker prescription, code N	Conditional	5
-	Person—timing of antithrombin therapy prescription, code N	Conditional	4
-	Person—timing of aspirin prescription, code N	Conditional	5
-	Person—timing of beta-blocker prescription, code N	Conditional	5
-	Person—timing of clopidogrel prescription, code N	Conditional	5
-	Person—timing of glycoprotein IIb/IIIa inhibitor prescription, code N	Conditional	4
-	Person—timing of statin prescription, code N	Conditional	5

Coronary artery cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	352651
Registration status:	Health, Standard 01/10/2008
DSS type:	Data Set Specification (DSS)
Scope:	This cluster collects information on the characteristics of and interventions performed for the coronary arteries during the current hospitalisation. The coronary arteries included in this cluster are: • Left anterior descending coronary artery • Inferior surface artery • Left circumflex coronary artery • Diagonal coronary artery • Left main coronary artery • Posterior descending artery • Right coronary artery

Collection and usage attributes

Collection methods:	When reporting the maximum stenosis in the coronary arteries, reporting of all the following coronary vessels is mandatory: • Diagonal coronary artery • Left anterior descending coronary artery • Inferior surface artery • Left circumflex coronary artery • Left main coronary artery • Posterior descending artery • Right coronary artery

Source and reference attributes

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

Relational attributes

Implementation in Data Set Specification:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Person—coronary artery bypass graft date, DDMMYYYY	Conditional	99
-	Person—coronary artery bypass graft location, code N	Conditional	7
-	Person—coronary artery stenosis location, code N	Mandatory	7
-	Person—count of coronary artery lesions attempted, total number N[N]	Conditional	99
-	Person—count of coronary artery lesions successfully dilated, total number N[N]	Conditional	99

-	Person—count of coronary artery stents, total number N[N]	Conditional	99
-	Person—maximum stenosis coronary artery, percentage N[NN]	Mandatory	1
-	Person—percutaneous coronary intervention procedure type, code N	Conditional	1
-	Person—primary percutaneous coronary intervention date, DDMMYYYY	Conditional	1
-	Person—primary percutaneous coronary intervention time, hhmm	Conditional	1
-	Person—rescue percutaneous coronary intervention date, DDMMYYYY	Conditional	1
-	Person—rescue percutaneous coronary intervention time, hhmm	Conditional	1
-	Person—revascularisation percutaneous coronary intervention date, DDMMYYYY	Conditional	1
-	Person—revascularisation percutaneous coronary intervention time, hhmm	Conditional	1

Electrocardiogram cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	351884
Registration status:	Health, Standard 01/10/2008
DSS type:	Data Set Specification (DSS)
Scope:	An electrocardiogram (ECG) measures the electrical activity of the heart over time. The evaluation of an ECG provides important diagnostic information relevant to the risk stratification, diagnosis and management of acute coronary syndromes. The electrocardiogram cluster collects information on the timing of each ECG and specific diagnostic characteristics determined from the ECG: • ECG change type and location • Bundle-branch block status • Q waves status • ST-segment elevation in lead V4R

Source and reference attributes

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

Relational attributes

Implementation in Data Set Specification:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Electrocardiogram — electrocardiogram date, DDMMYYYY	Mandatory	99
-	Electrocardiogram — electrocardiogram time, hhmm	Mandatory	99
-	Electrocardiogram — ST-segment-elevation in lead V4R indicator, yes/no code N	Conditional	99
-	Electrocardiogram — bundle-branch block status, code N	Conditional	1
-	Electrocardiogram — change location, code N	Conditional	1
-	Electrocardiogram — change type, code N	Conditional	99
-	Electrocardiogram — heart rhythm type, code N[N]	Mandatory	99
-	Electrocardiogram — lead V4R presence indicator, yes/no code N	Mandatory	99
-	Electrocardiogram — new Q waves indicator, yes/no code N	Conditional	99
-	Person — electrocardiogram Q waves indicator, yes/no code N	Mandatory	99

Functional stress test cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	351878
Registration status:	Health, Standard 01/10/2008
DSS type:	Data Set Specification (DSS)
Scope:	A functional stress test evaluates arterial blood flow to the heart muscle during increased cardiac work through physical exercise or pharmacological methods. The functional stress test cluster collects information on the timing, characteristics and results of a functional stress test performed during the current hospital presentation.

Source and reference attributes

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

Relational attributes

Implementation in Data Set Specification:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Functional stress test — stress test intensity, code N	Conditional	1
-	Functional stress test — assessment of cardiac perfusion, code N[N]	Conditional	1
-	Functional stress test — ischaemic and perfusion outcome result, code N	Conditional	1
-	Functional stress test — stress test element, code N	Conditional	1
-	Functional stress test — test date, DDMMYYYY	Conditional	1
-	Person — functional stress test performed indicator, yes/no code N	Mandatory	1

Ventricular ejection fraction cluster

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	351881
Registration status:	Health, Standard 01/10/2008
DSS type:	Data Set Specification (DSS)
Scope:	The ventricular ejection fraction is the fraction of blood pumped out of a ventricle with each heart beat. Impaired ventricular ejection fraction can be indicative of damage to the heart muscle, such as that sustained during myocardial infarction. The ventricular ejection fraction cluster collects information on the timing, measurement type and results of a ventricular ejection fraction measurement during the current hospital presentation.

Source and reference attributes

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

Relational attributes

Implementation in Data Set Specification:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Person—ventricular ejection fraction test performed indicator, yes/no code N	Mandatory	1
-	Ventricular ejection fraction test—test date, DDMMYYYY	Conditional	1
-	Ventricular ejection fraction test—test time, hhmm	Conditional	1
-	Ventricular ejection fraction test—test type, code N	Conditional	1
-	Ventricular ejection fraction—test result, code N	Conditional	1
-	Ventricular ejection fraction—test result, percentage N[N].N	Conditional	1

Electrocardiogram— electrocardiogram date, DDMMYYYY

Identifying and definitional attributes

Short name:	Date of electrocardiogram
Synonymous names:	Date of ECG
METeOR identifier:	343820
Registration status:	Health, Standard 01/10/2008
Definition:	The date an electrocardiogram (ECG) is performed for a person.
Data Element Concept:	Electrocardiogram—electrocardiogram date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Collection methods:	The date of ECG should be recorded irrespective of the setting (eg. pre-hospital setting, emergency department or inpatient ward). The date of ECG should be recorded each time an ECG is performed.

Relational attributes

Implementation in Data Set Specifications:	Electrocardiogram cluster Health, Standard 01/10/2008

Data set specification specific attributes

Information specific to this data set:	To be provided each time an ECG is performed.

Electrocardiogram— electrocardiogram time, hhmm

Identifying and definitional attributes

Short name:	Time of electrocardiogram
Synonymous names:	Time of ECG
METeOR identifier:	343831
Registration status:	Health, Standard 01/10/2008
Definition:	The time at which an electrocardiogram (ECG) is performed for a person.
Data Element Concept:	Electrocardiogram—electrocardiogram time

Value domain attributes

Representational attributes

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

Source and reference attributes

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

Data element attributes

Collection and usage attributes

Collection methods:	The time of ECG should be recorded irrespective of the setting (eg. pre-hospital setting, emergency department or inpatient ward). The time of ECG should be recorded each time an ECG is performed.

Relational attributes

Implementation in Data Set Specifications:	Electrocardiogram cluster Health, Standard 01/10/2008

Data set specification specific attributes

Information specific to this data set:	To be provided each time an ECG is performed.

Electrocardiogram— ST-segment-elevation in lead V4R indicator, yes/no code N

Identifying and definitional attributes

Short name:	Electrocardiogram - ST-segment-elevation in lead V4R
Synonymous names:	ECG - ST-segment-elevation lead V4R
METeOR identifier:	343889
Registration status:	Health, Standard 01/10/2008
Definition:	An indicator of whether ST-segment-elevation of greater than or equal to 1mm (0.1mV) in lead V4R of the electrocardiogram (ECG) is present, as represented by a code.
Data Element Concept:	Electrocardiogram—electrocardiogram ST-segment-elevation in lead V4R indicator

Value domain attributes

Representational attributes

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

Collection and usage attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes ST-segment-elevation >= 1 mm (0.1 mV) in lead V4R CODE 2 No ST-segment-elevation in lead V4R of <= 1 mm (0.1 mV) or no ST-segment-elevation in lead V4R CODE 9 Not stated/inadequately described Includes unknown
Collection methods:	The presence (or absence) of ST-segment elevation in lead V4R should be recorded when right-sided precordial leads are performed in the ECG.
Comments:	ST-segment elevation in lead V4R represents right ventricular infarction.

Relational attributes

Related metadata references:	See also Electrocardiogram—lead V4R presence indicator, yes/no code N Health, Standard 01/10/2008
Implementation in Data Set Specifications:	Electrocardiogram cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	Record when lead V4R was performed on the electrocardiogram.

Electrocardiogram—bundle-branch block status, code N

Identifying and definitional attributes

Short name:	Bundle-branch block status
METeOR identifier:	343866
Registration status:	Health, Standard 01/10/2008
Definition:	The bundle-branch block status identified on a person's electrocardiogram (ECG), as represented by a code.
Data Element Concept:	Electrocardiogram—bundle-branch block status

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	New
	2	Pre-existing
	3	Uncertain timing
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	To determine the bundle-branch block status, compare the current ECG to the preceding or most recently available ECG.
Collection methods:	Record for each ECG that indicates a bundle-branch block is present. Only one bundle-branch block status can be recorded for each ECG performed. Only one bundle-branch block can occur at any one time, but in any given person, a left bundle-branch block may occur at one timepoint and a right bundle-branch block at another time point. Therefore, there can only be one bundle-branch block per ECG but they may differ temporally.

Relational attributes

Implementation in Data Set Specifications:	Electrocardiogram cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	Record if a bundle-branch block has been detected on an electrocardiogram.

Electrocardiogram—change location, code N

Identifying and definitional attributes

Short name:	Electrocardiogram change location
METeOR identifier:	356835
Registration status:	Health, Standard 01/10/2008
Definition:	The area in which the change is located on the electrocardiogram (ECG), as represented by a code.
Data Element Concept:	Electrocardiogram—change location

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Inferior leads: II, III, aVF
2	Anterior leads: V1 to V4
3	Lateral leads: I, aVL, V5 to V6
4	True posterior: V1 V2

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 4 True posterior: V1 V2

True posterior is relevant only for tall R waves.

Data element attributes

Collection and usage attributes

Guide for use:

More than one code may be recorded.

Report in order of significance.

Where a change is located in all leads of the ECG codes 1, 2 and 3 should be recorded.

Record all codes that apply (code 9 is excluded from multiple coding).

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Relational attributes

Related metadata references: Supersedes Person—electrocardiogram change location, code N Health, Superseded 01/10/2008

Implementation in Data Set Specifications: Electrocardiogram cluster Health, Standard 01/10/2008

Data set specification specific attributes

Information specific to this data set: To be provided each time an ECG is performed.

Electrocardiogram—change type, code N

Identifying and definitional attributes

Short name:	Electrocardiogram change type
METeOR identifier:	356856
Registration status:	Health, Standard 01/10/2008
Definition:	The type of change to the heart rhythm seen on a person's electrocardiogram (ECG), as represented by a code.
Data Element Concept:	Electrocardiogram—change type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
10	ST-segment-elevation >= 1 mm (0.1 mV) in >= 2 contiguous limb leads
11	ST-segment-elevation >= 2 mm (0.2 mV) in >= 2 contiguous chest leads
12	ST-segment depression >= 0.5 mm (0.05 mV) in >= 2 contiguous leads (includes reciprocal changes)
20	T-wave inversion >= 2 mm (0.1 mV)
30	Significant Q waves
40	Left bundle-branch block (BBB)
41	Right bundle-branch block (BBB)
42	Indeterminate bundle-branch block (BBB)
90	Non specific

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

ST-segment changes

CODE 10 ST-segment-elevation >= 1 mm (0.1 mV) in >= 2 contiguous limb leads

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

CODE 11 ST-segment-elevation >= 2 mm (0.2 mV) in >= 2 contiguous chest leads

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

CODE 12 ST-segment depression >= 0.5 mm (0.05 mV) in >= 2 contiguous leads (includes reciprocal changes)

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

T-wave changes

CODE 20 T-wave inversion >= 2 mm (0.2 mV)

T-wave inversion of at least 2 mm (0.2 mV) including inverted T waves that are not indicative of acute MI.

Q wave changes

CODE 30 Significant Q waves

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

Bundle-branch block changes

CODE 40 Left bundle branch block (BBB)

Diffuse left bundle-branch block pattern.

CODE 41 Right bundle-branch block (BBB)

Diffuse right bundle-branch block pattern.

CODE 42 Indeterminate bundle-branch block (BBB)

Bundle-branch block pattern identified, but left or right location is unclear.

CODE 90 Non-specific

Changes not meeting the above criteria.

CODE 99 Not stated/inadequately described

Includes unknown.

Data element attributes

Collection and usage attributes

Guide for use: More than one code may be recorded.

Record all that apply (codes 90 and 99 are excluded from multiple coding).

Collection methods: Where codes 40, 41 or 42 are recorded Electrocardiogram - bundle-branch block status, code N must also be recorded.

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Relational attributes

Related metadata references: Supersedes Person—electrocardiogram change type, code N Health, Superseded 01/10/2008

Implementation in Data Set Specifications: Electrocardiogram cluster Health, Standard 01/10/2008

Data set specification specific attributes

Information specific to this data set: To be provided each time an ECG is performed.

Electrocardiogram—heart rhythm type, code N[N]

Identifying and definitional attributes

Short name:	Heart rhythm type
METeOR identifier:	361626
Registration status:	Health, Standard 01/10/2008
Definition:	The type of rhythm associated with the beating of the heart as determined from the electrocardiogram (ECG), as represented by a code.
Data Element Concept:	Electrocardiogram—heart rhythm type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Sinus rhythm
2	Atrial fibrillation
3	Atrial flutter
4	Second degree heart block
5	Complete heart block
6	Supraventricular tachycardia
7	Idioventricular rhythm
8	Ventricular tachycardia
9	Ventricular fibrillation
10	Paced
11	Other rhythm

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group

Relational attributes

Related metadata references:	Supersedes Person—heart rhythm type, code N[N] Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Electrocardiogram cluster Health, Standard 01/10/2008

Data set specification specific attributes

Information specific to this data set: To be provided each time an ECG is performed.

Electrocardiogram—lead V4R presence indicator, yes/no code N

Identifying and definitional attributes

Short name:	Electrocardiogram - lead V4R presence indicator
Synonymous names:	ECG - lead V4R indicator
METeOR identifier:	349656
Registration status:	Health, Standard 01/10/2008
Definition:	An indicator of whether lead V4R was performed on a person's electrocardiogram (ECG), as represented by a code.
Data Element Concept:	Electrocardiogram—lead V4R presence indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use: CODE 9 Not stated/inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Comments: Lead V4R represents a lead placed on the chest aligned with the right mid-clavicular line, in the 5th intercostal space. The measurements from this lead can identify right ventricular infarction.

Lead V4R should be performed in the context of inferior infarction, especially in the presence of haemodynamic compromise.

Relational attributes

Related metadata references: See also Electrocardiogram— ST-segment-elevation in lead V4R indicator, yes/no code N Health, Standard 01/10/2008

Implementation in Data Set Specifications: Electrocardiogram cluster Health, Standard 01/10/2008

Data set specification specific attributes

Information specific to this data set: To be provided each time an ECG is performed.

Electrocardiogram—new Q waves indicator, yes/no code N

Identifying and definitional attributes

Short name:	Electrocardiogram - new Q waves indicator
Synonymous names:	ECG - new Q waves
METeOR identifier:	343902
Registration status:	Health, Standard 01/10/2008
Definition:	Whether the Q waves identified on a person's follow-up electrocardiogram (ECG) is new, as represented by a code.
Data Element Concept:	Electrocardiogram—new Q waves indicator

Value domain attributes

Representational attributes

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

Collection and usage attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes (New Q waves) Use this code where the follow-up ECG identifies Q waves >=0.03 seconds in width and >=1mm (0.1mV) in depth in at least 2 contiguous leads that were <u>not</u> seen on the initial ECG CODE 2 No (Pre-existing Q waves) Use this code where the follow-up ECG identifies Q waves >=0.03 seconds in width and >=1mm (0.1mV) in depth in at least 2 contiguous leads that were <u>already</u> seen on the initial ECG CODE 9 Not stated/inadequately described Includes unknown
Collection methods:	Do not record whether the Q waves are new or not on the initial ECG. This data element should only be recorded for follow-up ECGs.
Comments:	This data element identifies if new Q waves are present on the follow-up ECG. This information is valuable in coding transmural myocardial infarction.

Relational attributes

Related metadata references:	See also Person—electrocardiogram Q waves indicator, yes/no code N Health, Standard 01/10/2008
Implementation in Data Set Specifications:	Electrocardiogram cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	Record if Q waves are present on the follow up electrocardiogram.

Episode of admitted patient care—admission date, DDMMYYYY

Identifying and definitional attributes

Short name:	Admission date
METeOR identifier:	269967
Registration status:	Health, Standard 01/03/2005
Definition:	Date on which an admitted patient commences an episode of care.
Data Element Concept:	Episode of admitted patient care—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.pdf (14.44 KB)

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

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

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

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

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

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

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

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

Health, Superseded 04/07/2007

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

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

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

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

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

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

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

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

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

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

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

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

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

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

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

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

Episode of admitted patient care—admission time, hhmm

Identifying and definitional attributes

Short name:	Admission time
METeOR identifier:	269972
Registration status:	Health, Standard 01/03/2005
Definition:	Time at which an admitted patient commences an episode of care.
Data Element Concept:	Episode of admitted patient care—admission time

Value domain attributes

Representational attributes

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

Source and reference attributes

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

Data element attributes

Collection and usage attributes

Comments:	Required to identify the time of commencement of the episode or hospital stay, for calculation of waiting times and length of stay.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Admission time, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.48 KB) Is used in the formation of Non-admitted patient emergency department service episode—waiting time (to hospital admission), total hours and minutes NNNN Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Episode of admitted patient care—separation date, DDMMYYYY

Identifying and definitional attributes

Short name:	Separation date
METeOR identifier:	270025
Registration status:	Health, Standard 01/03/2005
Definition:	Date on which an admitted patient completes an episode of care.
Data Element Concept:	Episode of admitted patient care—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.pdf (15.15 KB)

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

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

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

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

	length of stay (including leave days) (postnatal), total N[NN] Health, Standard 04/07/2007
	Is used in the formation of Episode of admitted patient care—length of stay (excluding leave days), total N[NN] Health, Standard 01/03/2005
	Is used in the formation of Episode of care—number of psychiatric care days, total N[NNNN] Health, Standard 01/03/2005
	Is used in the formation of Episode of admitted patient care—length of stay (including leave days), total N[NN] Health, Superseded 04/07/2007
	Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA Health, Standard 01/03/2005
	Is used in the formation of Episode of admitted patient care (postnatal)—length of stay (including leave days), total N[NN] Health, Superseded 04/07/2007
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008
	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005
	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008
	Admitted patient care NMDS Health, Superseded 07/12/2005
	Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006
	Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008
	Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008
	Admitted patient mental health care NMDS Health, Superseded 23/10/2006
	Admitted patient mental health care NMDS Health, Superseded 07/12/2005
	Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008
	Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008
	Admitted patient palliative care NMDS Health, Superseded 07/12/2005
	Admitted patient palliative care NMDS 2006-2007 Health, Superseded 23/10/2006
	Admitted patient palliative care NMDS 2007-08 Health, Superseded 05/02/2008
	Admitted patient palliative care NMDS 2008-09 Health, Standard 05/02/2008
	AROC inpatient data set specification Health, Candidate 14/02/2007
	Perinatal NMDS Health, Superseded 06/09/2006
	Perinatal NMDS Health, Superseded 07/12/2005
	Perinatal NMDS 2007-2008 Health, Superseded 05/02/2008
	Perinatal NMDS 2008-2009 Health, Standard 05/02/2008

Episode of admitted patient care—separation mode, code N

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

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

Collection and usage attributes

Guide for use:

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

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

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

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

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

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

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008

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

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

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

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

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

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

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

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

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

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

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

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

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

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

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

Episode of care—principal diagnosis, code (ICD-10-AM 6th edn) ANN{.N[N]}

Identifying and definitional attributes

Short name:	Principal diagnosis
METeOR identifier:	361034
Registration status:	Health, Standard 05/02/2008
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:	Episode of care—principal diagnosis

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	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 5th edn) ANN{.N[N]} Health, Superseded 05/02/2008

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

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

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

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

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

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

Episode of care—principal source of funding, hospital code NN

Identifying and definitional attributes

Short name:	Funding source for hospital patient
METeOR identifier:	339080
Registration status:	Health, 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:	Episode of care—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 Health, Superseded 29/11/2006

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

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

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

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

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

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

Establishment—organisation identifier (Australian), NNX[X]NNNNN

Identifying and definitional attributes

Short name:	Establishment identifier
METeOR identifier:	269973
Registration status:	Health, Standard 01/03/2005
Definition:	The identifier for the establishment in which episode or event occurred. Each separately administered health care establishment to have a unique identifier at the national level.
Data Element Concept:	Establishment—organisation identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	NNX[X]NNNNN
Maximum character length:	9

Data element attributes

Collection and usage attributes

Guide for use:	Concatenation of: Australian state/territory identifier (character position 1); Sector (character position 2); Region identifier (character positions 3-4); and Organisation identifier (state/territory), (character positions 5-9).
Comments:	Establishment identifier should be able to distinguish between all health care establishments nationally.

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:	Supersedes Establishment identifier, version 4, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.97 KB) Is formed using Establishment—Australian state/territory identifier, code N Health, Standard 01/03/2005 Is formed using Establishment—organisation identifier (state/territory), NNNNN Health, Standard 01/03/2005 Is formed using Establishment—sector, code N Health, Standard 01/03/2005 Is formed using Establishment—region identifier, X[X] Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008 Admitted patient mental health care NMDS Health, Superseded

23/10/2006

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Elective surgery waiting times (census data) NMDS Health, Standard 07/12/2005

Elective surgery waiting times (census data) NMDS Health, Superseded 07/12/2005

Elective surgery waiting times (removals data) NMDS Health, Standard 07/12/2005

Elective surgery waiting times (removals data) NMDS Health, Superseded 07/12/2005

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

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

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

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

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

Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Mental health establishments NMDS 2008-2009 Health, Standard 05/02/2008

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

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

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

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

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

Outpatient care NMDS Health, Superseded 04/07/2007

Outpatient care NMDS Health, Standard 04/07/2007

Perinatal NMDS Health, Superseded 06/09/2006

Perinatal NMDS Health, Superseded 07/12/2005

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

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

Public hospital establishments NMDS Health, Superseded 21/03/2006

Public hospital establishments NMDS Health, Superseded 23/10/2006

Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Public hospital establishments NMDS 2008-2009 Health, Standard 05/02/2008

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

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

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

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

Functional stress test— stress test intensity, code N

Identifying and definitional attributes

Short name:	Functional stress test intensity
METeOR identifier:	344443
Registration status:	Health, Standard 01/10/2008
Definition:	The intensity of the functional stress test performed on a person, as represented by a code.
Data Element Concept:	Functional stress test—stress test intensity

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Maximal (symptom limited)
	2	Submaximal
	3	Rest / distribution study
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Maximal (symptom limited)

Use this code when the intensity of the stress test is to increase the person's heart rate with the exercise to 85-90% of their predicted maximum heart rate.

CODE 2 Submaximal

Use this code when the intensity of the stress test is limited to increasing the person's heart rate with the exercise to 120 beats per minute or 70% of their predicted maximum heart rate.

CODE 3 Rest/distribution study

Use this code when a Thallium (nuclear) study has been undertaken for the assessment of viability, where no exercise or pharmacologic stress component has been undertaken

CODE 9 Not stated/inadequately described

Not for use in primary data collections.

Data element attributes

Collection and usage attributes

Collection methods:	The intensity is determined and recorded by the clinicians performing the test.
Comments:	The stress test intensity has implications for the interpretation of the test results.

Relational attributes

Implementation in Data Set Specifications:	Functional stress test cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	To be provided when a functional stress test is performed.

Functional stress test—assessment of cardiac perfusion, code N[N]

Identifying and definitional attributes

Short name:	Functional stress test assessment of cardiac perfusion
Synonymous names:	Functional stress test method
METeOR identifier:	344432
Registration status:	Health, Standard 01/10/2008
Definition:	The method of functional assessment of cardiac perfusion undertaken in a person's stress test, as represented by a code.
Data Element Concept:	Functional stress test—assessment of cardiac perusion

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Exercise tolerance
2	Pharmacological

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Exercise tolerance

Use this code when a treadmill, bicycle or arm-exercise was used to increase the cardiac work.

CODE 2 Pharmacological

Use this code when any form of pharmacologic augmentation was used to increase cardiac work. For example, dobutamine, atropine or persantin.

CODE 9 Not stated/inadequately described

Not for use in primary data collections.

Data element attributes

Relational attributes

Implementation in Data Set Specifications:	Functional stress test cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	To be provided when a functional stress test is performed.

Functional stress test—ischaemic and perfusion outcome result, code N

Identifying and definitional attributes

Short name:	Functional stress ischaemic and perfusion outcome result
Synonymous names:	Functional stress test result
METeOR identifier:	349703
Registration status:	Health, Standard 01/10/2008
Definition:	The result of the person's functional stress test in terms of ischaemic and perfusion outcomes, as represented by a code.
Data Element Concept:	Functional stress test—ischaemic and perfusion outcome result

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	No abnormal outcome
2	Ischaemic discomfort and/or ST shift
3	Fixed perfusion or wall motion defects only
4	Reversible perfusion or wall motion defects only
5	Fixed and reversible perfusion and wall motion defects
6	Equivocal

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Depending on the method used for the stress test, and therefore the way the results are viewed, some of these codes will not be applicable. For example where an ECG was used for the stress test codes 3,4 and 5 will not be applicable.

CODE 1 No abnormal outcome

Use this code when the stress test result identifies no evidence of ischaemia (i.e. no typical angina pain and no ST shifts).

CODE 2 Ischaemic discomfort and/or ST shift

Use this code when the stress test result identifies either:

- Both ischaemic discomfort and ST shift greater than or equal to 1 mm (0.1 mV) (horizontal or downsloping); or
- new ST shift greater than or equal to 2 mm (0.2 mV) (horizontal or down-sloping) believed to represent ischaemia even in the absence of ischaemic discomfort.

This code only applies to stress tests where no imaging component was performed.

CODE 3 Fixed perfusion or wall motion defects only

Use this code when the stress test result identifies fixed perfusion defects only. This means the presence of non-viable myocardium with no areas of inducible ischaemia during functional stress testing.

This code only applies to stress tests where an imaging component was performed.

CODE 4 Reversible perfusion or wall motion defects only

Use this code when the stress test result identifies reversible perfusion defects only. This means the presence of inducible defects in myocardial perfusion with underlying viable myocardium in all areas.

This code only applies to stress tests where an imaging component was performed.

CODE 5 Fixed and reversible perfusion or wall motion defects

Use this code when the stress test result identifies reversible and fixed perfusion defects. This means the presence of non-viable myocardial areas, together with areas of inducible defects in reperfusion.

This code only applies to stress tests where an imaging component was performed.

CODE 6 Equivocal

Use this code when the stress test result identifies either:

- Typical ischaemic pain but no ST shift greater than or equal to 1 mm (0.1 mV) (horizontal or downsloping); OR ST shift of 1 mm (0.1 mV) (horizontal or downsloping) but no ischaemic discomfort.
- Defect on myocardial imaging of uncertain nature or significance.

Data element attributes

Relational attributes

Related metadata references:	Supersedes Person—functional stress test ischaemic result, code N Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Functional stress test cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	To be provided when a functional stress test is performed.

Functional stress test—stress test element, code N

Identifying and definitional attributes

Short name:	Functional stress test element
METeOR identifier:	356883
Registration status:	Health, Standard 01/10/2008
Definition:	The element included in a person's functional stress test, as represented by a code.
Data Element Concept:	Functional stress test—functional stress test element

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	ECG monitoring
2	Echocardiography
3	Radionuclide (perfusion) imaging (e.g. Thallium, Sestamibi)
4	Positron Emission Tomography (PET)
5	Magnetic Resonance Imaging (MRI)

Supplementary values:

Value	Meaning
9	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:	More than one code may be recorded (code 9 is excluded from multiple coding).

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group

Relational attributes

Related metadata references:	Supersedes Person—functional stress test element, code N Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Functional stress test cluster Health, Standard 01/10/2008

Functional stress test—test date, DDMMYYYY

Identifying and definitional attributes

Short name:	Date of functional stress test
METeOR identifier:	347054
Registration status:	Health, Standard 01/10/2008
Definition:	The date when a functional stress test is performed on a person.
Data Element Concept:	Functional stress test—test date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	The date should always be recorded when a functional stress test is performed.

Relational attributes

Implementation in Data Set Specifications:	Functional stress test cluster Health, Standard 01/10/2008

Health service event—presentation date, DDMMYYYY

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

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

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

The date that the patient presents is not necessarily:

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

Source and reference attributes

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

Relational attributes

Related metadata references:

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

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

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

Is used in the formation of Non-admitted patient emergency department service episode—waiting time (to hospital

admission), total hours and minutes NNNN Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008

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

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

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

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

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

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

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

Data set specification specific attributes

Information specific to this data set:

This data element should only be collected for patients who presented to the emergency department for treatment related to acute coronary syndromes.

Health service event—presentation time, hhmm

Identifying and definitional attributes

Short name:	Time patient presents
METeOR identifier:	270080
Registration status:	Health, Standard 01/03/2005
Definition:	The time at which the patient presents for the delivery of a service.
Data Element Concept:	Health service event—presentation time

Value domain attributes

Representational attributes

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

Source and reference attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

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

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

The time that the patient presents is not necessarily:

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

Source and reference attributes

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

Relational attributes

Related metadata references:

Supersedes Time patient presents, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.17 KB)

Is used in the formation of Non-admitted patient emergency department service episode—waiting time (to service delivery),

	total minutes NNNNN Health, Standard 01/03/2005 Is used in the formation of Non-admitted patient emergency department service episode—service episode length, total minutes NNNNN Health, Standard 01/03/2005 Is used in the formation of Non-admitted patient emergency department service episode—waiting time (to hospital admission), total hours and minutes NNNN Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008 Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008 Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005 Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006 Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006 Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008 Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Data set specification specific attributes

Information specific to this data set:	This data element should only be collected for patients who presented to the emergency department for treatment related to acute coronary syndromes.

Health service event—referral to rehabilitation service date, DDMMYYYY

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation:	Cardiovascular Data Working Group

Relational attributes

Related metadata references:	Supersedes Date of referral to rehabilitation, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.17 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008 Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008 Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006 Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007 Cardiovascular disease (clinical) DSS Health, Standard 04/07/2007

Data set specification specific attributes

Information specific to this data set:	Required to derive those referred to a rehabilitation service

from those eligible to attend and who actually attend. This metadata item can be used to determine the time lag between referral and commencement of rehabilitation.

Laboratory standard—upper limit of normal range for creatine kinase isoenzyme, total units per litre N[NNN]

Identifying and definitional attributes

Short name:	Creatine kinase isoenzyme—upper limit of normal range (U/L)
METeOR identifier:	349630
Registration status:	Health, Standard 01/10/2008
Definition:	Laboratory standard for the value of creatine kinase (CK) isoenzyme measured in units per litre that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for creatine kinase isoenzyme

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
9998	Not measured
9999	Not stated/inadequately described

Proposed unit of measure: Units per litre (U/L)

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the creatine kinase normal reference range for the testing laboratory.
Comments:	There are three different CK isoenzyme sub-forms: - CK-MM (skeletal muscle) - CK-MB (cardiac muscle) - CK-BB (brain tissue)

Relational attributes

Related metadata references:	See also Person—creatine kinase isoenzyme level (measured), total units per litre N[NNN] Health, Standard 01/10/2008 See also Person—creatine kinase isoenzyme measured date, DDMMYYYY Health, Candidate 04/03/2008 See also Person—creatine kinase isoenzyme measured time, hhmm Health, Candidate 04/03/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total micrograms per litre N[NNN]

Identifying and definitional attributes

Short name:	Creatine kinase MB isoenzyme—upper limit of normal range (micrograms per litre)
METeOR identifier:	359287
Registration status:	Health, Standard 01/10/2008
Definition:	Laboratory standard for the value of creatine kinase myocardial band (CK-MB) isoenzyme measured in micrograms per litre that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
9998	Not measured
9999	Not stated/inadequately described

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

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group.

Relational attributes

Related metadata references: Supersedes Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total micrograms per litre N[NNN] Health, Superseded 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total units per litre N[NNN]

Identifying and definitional attributes

Short name:	Creatine kinase MB isoenzyme—upper limit of normal range (units per litre)
METeOR identifier:	356596
Registration status:	Health, Standard 01/10/2008
Definition:	Laboratory standard for the value of creatine kinase myocardial band (CK-MB) isoenzyme measured in units per litre that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
9998	Not measured
9999	Not stated/inadequately described

Proposed unit of measure: Units per litre (U/L)

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group.

Relational attributes

Related metadata references: Supersedes Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total international units N[NNN] Health, Superseded 01/10/2008

See also Person—creatine kinase-myocardial band isoenzyme level (measured), total units per litre N[NNN] Health, Standard 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Laboratory standard—upper limit of normal range for troponin assay, total micrograms per litre N[NNN]

Identifying and definitional attributes

Short name:	Troponin assay—upper limit of normal range (micrograms per litre)
METeOR identifier:	359315
Registration status:	Health, Standard 01/10/2008
Definition:	Laboratory standard for the value of 'troponin T' or 'troponin I' measured in micrograms per litre that is the upper boundary of the normal reference range.
Data Element Concept:	Person—troponin assay type

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
9998	Not measured
9999	Not stated/inadequately described

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

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: Record the upper limit of normal (usually the ninety-ninth percentile of a normal population) for the individual laboratory.

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Relational attributes

Related metadata references: Supersedes Laboratory standard—upper limit of normal range for troponin assay, total micrograms per litre N[NNN] Health, Superseded 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Laboratory standard—upper limit of normal range of glycosylated haemoglobin, percentage N[N].N

Identifying and definitional attributes

Short name:	Glycosylated Haemoglobin—upper limit of normal range (percentage)
METeOR identifier:	270333
Registration status:	Health, Standard 01/03/2005
Definition:	Laboratory standard for the value of glycosylated haemoglobin (HbA1c) measured as a percentage that is the upper boundary of the normal range.
Data Element Concept:	Laboratory standard—upper limit of normal range of glycosylated haemoglobin

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
99.9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the HbA1c normal reference range from the laboratory result.
Collection methods:	This value is usually notified in patient laboratory results and may vary for different laboratories.
Comments:	HbA1c results vary between laboratories; use the same laboratory for repeated testing.

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:	See also Person—glycosylated haemoglobin level (measured), percentage N[N].N Health, Standard 01/03/2005 Supersedes Glycosylated Haemoglobin (HbA1c) - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.93 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008 Diabetes (clinical) DSS Health, Superseded 21/09/2005

Non-admitted patient emergency department service episode—transport mode (arrival), code N

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Ambulance, air ambulance or helicopter rescue service
2	Police/correctional services vehicle
8	Other
9	Not stated/unknown

Supplementary values:

Collection and usage attributes

Guide for use: CODE 8 Other

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

Data element attributes

Source and reference attributes

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

Relational attributes

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

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

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

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

Non-admitted patient emergency department care NMDS

Health, Superseded 23/10/2006

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

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

Data set specification specific attributes

Information specific to this data set: This data element should only be collected for patients who presented to the emergency department for treatment related to acute coronary syndromes.

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

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

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

Data element attributes

Collection and usage attributes

Collection methods:

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

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

Source and reference attributes

Origin:	National Triage Scale, Australasian College for Emergency Medicine

Relational attributes

Related metadata references:	Supersedes Triage category, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.26 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008
	Acute coronary syndrome (clinical) DSS Health, Superseded

07/12/2005

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

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

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

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

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

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

Data set specification specific attributes

Information specific to this data set: This data element should only be collected for patients who presented to the emergency department for treatment related to acute coronary syndromes.

Non-admitted patient emergency department service episode—triage date, DDMMYYYY

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation:	Australian Government Department of Health and Ageing

Relational attributes

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

Data set specification specific attributes

Information specific to this data set:	This data element should only be collected for patients who presented to the emergency department for treatment related to acute coronary syndromes.

Non-admitted patient emergency department service episode—triage time, hhmm

Identifying and definitional attributes

Short name:	Time of triage
METeOR identifier:	313817
Registration status:	Health, Standard 07/12/2005
Definition:	The time at which the patient is **triaged**.
Context:	Emergency Department care.
Data Element Concept:	Non-admitted patient emergency department service episode—triage time

Value domain attributes

Representational attributes

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

Source and reference attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation:	Australian Government Department of Health and Ageing

Relational attributes

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

Data set specification specific attributes

Information specific to this data set: This data element should only be collected for patients who presented to the emergency department for treatment related to acute coronary syndromes.

Non-admitted patient emergency department service episode—type of visit to emergency department, code N

Identifying and definitional attributes

Short name:	Type of visit to emergency department
METeOR identifier:	270362
Registration status:	Health, Standard 01/03/2005
Definition:	The reason the patient presents to an emergency department, as represented by a code.
Data Element Concept:	Non-admitted patient emergency department service episode—type of visit to emergency department

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Emergency presentation: attendance for an actual or suspected condition which is sufficiently serious to require acute unscheduled care.
2	Return visit, planned: presentation is planned and is a result of a previous emergency department presentation or return visit.
3	Pre-arranged admission: a patient who presents at the emergency department for either clerical, nursing or medical processes to be undertaken, and admission has been pre-arranged by the referring medical officer and a bed allocated.
4	Patient in transit: the emergency department is responsible for care and treatment of a patient awaiting transport to another facility.
5	Dead on arrival: a patient who is dead on arrival at the emergency department.

Data element attributes

Collection and usage attributes

Comments:	Required for analysis of emergency department services.

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Type of visit to emergency department, version 2,

	DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.64 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008 Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008 Non-admitted patient emergency department care NMDS Health, Superseded 07/12/2005 Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006 Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006 Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008 Non-admitted patient emergency department care NMDS 2008-2009 Health, Standard 05/02/2008

Data set specification specific attributes

Information specific to this data set:	This data element should only be collected for patients who presented to the emergency department for treatment related to acute coronary syndromes.

Person with acute coronary syndrome—acute coronary syndrome related clinical event date, DDMMYYYY

Identifying and definitional attributes

Short name:	Date of acute coronary syndrome related clinical event
METeOR identifier:	349645
Registration status:	Health, Standard 01/10/2008
Definition:	The date a person experienced an acute coronary syndrome related clinical event.
Data Element Concept:	Person with acute coronary syndrome—acute coronary syndrome related clinical event date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	A date should be recorded for each of the specified clinical events that the person experiences while in hospital.
Comments:	An acute coronary syndrome (ACS) related clinical event is a clinical event which can affect the health outcomes of a person with ACS. Information on the occurrence of these clinical events in people with ACS is required due to an emerging appreciation of their relationship with late mortality.

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome clinical event cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	If a clinical event has occurred, record the date when it was experienced by the person.
Information specific to this data set:	The date is to be provided for each clinical event experienced during this hospital presentation.

Person with acute coronary syndrome—acute coronary syndrome related clinical event time, hhmm

Identifying and definitional attributes

Short name:	Time of acute coronary syndrome related clinical event
METeOR identifier:	349809
Registration status:	Health, Standard 01/10/2008
Definition:	The time a person experienced an acute coronary syndrome related clinical event.
Data Element Concept:	Person with acute coronary syndrome—acute coronary syndrome related clinical event time

Value domain attributes

Representational attributes

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

Source and reference attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	A time should be recorded for each of the specified clinical events that the person experiences.
Comments:	An acute coronary syndrome (ACS) related clinical event is a clinical event which can affect the health outcomes of a person with ACS. Information on the occurrence of these clinical events in people with ACS is required due to an emerging appreciation of their relationship with late mortality.

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome clinical event cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	If a clinical event has occurred, record the time when it was experienced by the person.
Information specific to this data set:	The time is to be provided for each clinical event experienced during this hospital presentation.

Person with acute coronary syndrome—bleeding location, instrumented code N(N)

Identifying and definitional attributes

Short name:	Instrumented bleeding location
Synonymous names:	Instrumented bleeding site
METeOR identifier:	344787
Registration status:	Health, Standard 01/10/2008
Definition:	The location of the person's bleeding episode, arising from an instrumented site,as represented by a code.
Data Element Concept:	Person with acute coronary syndrome—bleeding location

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Percutaneous coronary procedure arterial access site
2	Coronary artery bypass graft site
3	Gastrointestinal site
4	Genitourinary site
5	Intracranial site
6	Pulmonary site
7	Pericardial site
8	Other site(s)
9	Unidentified site

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Percutaneous coronary procedure arterial access site

Use this code when the person's bleeding is originating from the site of arterial access for a percutaneous coronary procedure. Procedures may include cardiac catheterisation, percutaneous coronary intervention, angiogram, intra-aortic balloon pump and/or arterial pressure monitoring sheaths.

CODE 2 Coronary artery bypass graft site

Use this code when the person's bleeding is originating from the site of a coronary artery bypass graft.

CODE 3 Gastrointestinal site

Use this code when the person's bleeding is originating from the gastrointestinal area with mechanical instrumentation.

CODE 4 Genitourinary site

Use this code when the person's bleeding is originating from

the genitourinary area with mechanical instrumentation.

CODE 5 Intracranial site

Use this code when the person's bleeding is originating from an intracranial site with mechanical instrumentation.

CODE 6 Pulmonary site

Use this code when the person's bleeding is originating from a pulmonary site with mechanical instrumentation.

CODE 7 Pericardial site

Use this code when the person's bleeding is originating from the pericardium, following percutaneous coronary intervention. This code does not include bleeding that is secondary to a coronary artery bypass graft.

CODE 8 Other site(s)

Use this code when the person's bleeding is originating from a site with mechanical instrumentation that is not listed in codes 1-7, such as central line access.

CODE 9 Unidentified site

Use this code when the person has a fall in haemoglobin without an identifiable instrumented site of bleeding.

CODE 99 Not stated/inadequately described

Not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use: Record the location of all bleeding events that occur. More than one code can be applied.

Relational attributes

Related metadata references: See also Person with acute coronary syndrome—bleeding location, non-instrumented code N(N) Health, Standard 01/10/2008

See also Person—bleeding episode status, Thrombolysis in Myocardial Infraction (TIMI) code N Health, Standard 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Person with acute coronary syndrome—bleeding location, non-instrumented code N(N)

Identifying and definitional attributes

Short name:	Non-instrumented bleeding location
Synonymous names:	Non-instrumented bleeding site
METeOR identifier:	372012
Registration status:	Health, Standard 01/10/2008
Definition:	The location of the person's bleeding episode, arising from a non-instrumented site, as represented by a code.
Data Element Concept:	Person with acute coronary syndrome—bleeding location

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Gastrointestinal site
2	Genitourinary site
3	Intracranial site
4	Pulmonary site
5	Pericardial site
6	Other site(s)
7	Unidentified site

Supplementary values:

99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

NOTE: Excludes bleeding arising from instrumented sites.

CODE 1 Gastrointestinal site

Use this code when the person's spontaneous bleeding is originating from the gastrointestinal area.

CODE 2 Genitourinary site

Use this code when the person's spontaneous bleeding is originating from the genitourinary area.

CODE 3 Intracranial site

Use this code when the person's spontaneous bleeding is originating from an intracranial site.

CODE 4 Pulmonary site

Use this code when the person's spontaneous bleeding is originating from a pulmonary site.

CODE 5 Pericardial site

Use this code when the person's spontaneous bleeding is originating from the pericardium.

CODE 6 Other site(s)

Use this code when the person's spontaneous bleeding is originating from a site not listed in codes 1-5.

CODE 7 Unidentified site

Use this code when the person has a fall in haemoglobin without an identifiable spontaneous site of bleeding.

CODE 99 Not stated/inadequately described

Not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use: Record the location of all bleeding events that occur. More than one code can be applied.

Relational attributes

Related metadata references: See also Person with acute coronary syndrome—bleeding location, instrumented code N(N) Health, Standard 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Person with acute coronary syndrome—lifestyle counselling type, code N

Identifying and definitional attributes

Short name:	Lifestyle counselling type
METeOR identifier:	344710
Registration status:	Health, Standard 01/10/2008
Definition:	The counselling a person has received to modify lifestyle behaviour/s relevant to acute coronary syndromes, as represented by a code.
Data Element Concept:	Person with acute coronary syndrome—lifestyle counselling type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Diet
2	Physical activity
3	Smoking cessation
4	Weight management

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

Counselling includes any method of individual or group counselling or advice directed towards any of the specific lifestyle behaviours.

This metadata item refers to counselling that was conducted by a healthcare professional during the hospital stay. This may inclue counselling that was performed in conjunction with referral to a cardiac rehabilitation service.

CODE 1 Diet

Use this code where a person has received counselling on their diet.

CODE 2 Physical activity

Use this code where a person has received counselling encouraging at least 30 to 60 minutes of physical activity in at least five sessions per week.

CODE 3 Smoking cessation

Use this code where a person has received counselling regarding the importance of stopping smoking.

CODE 4 Weight management

Use this code where a person, whose weight is greater than 120% of the ideal weight for height, has received counselling on weight management.

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Person with acute coronary syndrome—pharmacotherapy type prescribed in hospital, code N[N]

Identifying and definitional attributes

Short name:	Pharmacotherapy type prescribed for acute coronary syndrome in hospital
Synonymous names:	ACS pharmacotherapy type prescribed
METeOR identifier:	344344
Registration status:	Health, Standard 01/10/2008
Definition:	The type of pharmacotherapy prescribed to a person in hospital for the treatment of acute coronary syndrome, as represented by a code.
Data Element Concept:	Person with acute coronary syndrome—pharmacotherapy type prescribed in hospital

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Aspirin
2	Angiotensin converting enzyme (ACE) inhibitor
3	Angiotensin II receptor blocker
4	Antithrombin
5	Beta-blocker
6	Clopidogrel
7	Fibrinolytic
8	Glycoprotein IIb/IIIa receptor antagonist
9	Statin

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Aspirin

Includes: aspirin, astrix, cardiprin, cartia, aspro, disprin and solprin

CODE 2 Angiotensin converting enzyme (ACE) inhibitor

Includes: captopril, enalapril, fosinopril, lisinopril, perindopril, quinapril, ramipril and trandolapril

CODE 3 Angiotensin II receptor blocker

Includes: candesartan, eprosartan, irbesartan, losartin and temisartan

CODE 4 Antithrombin

Includes: dalteparin, danaparoid, enoxaparin, heparin,

phenindione, warfarin, bivalirudin, fondaparinux, lepirudin

CODE 5 Beta-blocker

Includes: atenolol, bisoprolol, carvedilol, esmolol, labetolol, metoprolol, oxprenolol, pindolol, propranolol and sotalol

CODE 6 Clopidogrel

Includes: iscover and plavix

CODE 7 Fibrinolytic

Includes: streptokinase, tissue plasminogen activator (t-PA) (alteplase), reteplase (r-PA) and tenecteplase (TNK t-PA)

CODE 8 Glycoprotein IIb/IIIa receptor

Includes: abciximab, eptifibatide and tirofiban

CODE 9 Statin

Includes: atorvastatin, fluvastatin, pravastatin and simvastatin

Data element attributes

Collection and usage attributes

Guide for use:	A person may be prescribed one or more type of medication for acute coronary syndromes. Therefore more than one code may be recorded.
Collection methods:	This information should be recorded at the end of the person's hospital stay involving the treatment of acute coronary syndromes.
Comments:	The purpose of this data element is to collect information on the prescription of pharmacotherapy recommended for the treatment of acute coronary syndromes in the national guidelines. Additional information on the specific drug types prescribed is not required for this quality purpose. The health service may choose to collect additional information on the specific drug types prescribed within each of the core pharmacotherapies.

Source and reference attributes

Reference documents:	National Heart Foundation of Australia & Cardiac Society of Australia and New Zealand. Guidelines for the management of acute coronary syndromes 2006. Med J Aust 2006; 184; S1-S32. © MJA 2006

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008

Data set specification specific attributes

Information specific to this data set:	Codes provided for each of those prescribed during this hospital presentation.

Person with acute coronary syndrome—pharmacotherapy type taken post discharge from hospital, code N[N]

Identifying and definitional attributes

Short name:	Pharmacotherapy type taken for acute coronary syndrome post discharge
METeOR identifier:	344822
Registration status:	Health, Standard 01/10/2008
Definition:	The type of pharmacotherapy being taken by a person for the treatment of acute coronary syndrome following discharge from hospital, as represented by a code.
Data Element Concept:	Person with acute coronary syndrome—pharmacotherapy type taken post discharge from hospital

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N[N]	
Maximum character length:	2	
Permissible values:	Value	Meaning
	1	Aspirin
	2	Angiotensin converting enzyme (ACE) inhibitor
	3	Angiotensin II receptor blocker
	4	Beta-blocker
	5	Clopidogrel
	6	Statin
Supplementary values:	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Aspirin

Includes: aspirin, astrix, cardiprin, cartia, aspro, disprin and solprin

CODE 2 Angiotensin converting enzyme (ACE) inhibitor

Includes: captopril, enalapril, fosinopril, lisinopril, perindopril, quinapril, ramipril and trandolapril

CODE 3 Angiotensin II receptor blocker

Includes: candesartan, eprosartan, irbesartan, losartin and temisartan

CODE 4 Beta-blocker

Includes: atenolol, bisoprolol, carvedilol, esmolol, labetolol, metoprolol, oxprenolol, pindolol, propranolol and sotalol

CODE 5 Clopidogrel

Includes: iscover and plavix

CODE 6 Statin

Includes: atorvastatin, fluvastatin, pravastatin and simvastatin

Data element attributes

Collection and usage attributes

Guide for use: A person may be taking one or more type of medication for acute coronary syndromes (ACS). Therefore more than one code may be recorded.

Collection methods: Following a person's hospital stay for ACS, follow-up consultations with a clinician may occur at various intervals, such as 3, 6 or 12 months after discharge from hospital. The medications being taken by the person at the time of each follow-up consultation should be recorded.

Comments: The pharmacotherapies for the treatment of ACS that could be taken post discharge from hospital are different from the types that could be taken during the hospital stay as not all of the pharmacotherapies used for the treatment of ACS are for out of hospital use.

Relational attributes

Implementation in Data Set Specifications: Acute coronary syndrome pharmacotherapy data cluster
Health, Standard 01/10/2008

Data set specification specific attributes

Information specific to this data set: To be provided at the follow-up visit following discharge from the hospital for each of the relevant pharmacotherapy types prescribed.

Person with acute coronary syndrome—type of acute coronary syndrome related clinical event experienced, code N[N]

Identifying and definitional attributes

Short name:	Acute coronary syndrome related clinical event type
METeOR identifier:	338314
Registration status:	Health, Standard 01/10/2008
Definition:	The type of acute coronary syndrome related clinical event, as represented by a code.
Data Element Concept:	Person with acute coronary syndrome—type of acute coronary syndrome related clinical event

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Cardiogenic shock
2	Cardiac rupture
3	Cardiac arrest
4	New or recurrent myocardial infarction
5	Stroke
6	Acute pulmonary oedema
7	Recurrent rest angina with electrocardiogram changes
8	Recurrent rest angina without electrocardiogram changes
9	New onset arrhythmia: atrial
10	New onset arrhythmia: ventricular
11	New onset arrhythmia: heart block (1,2,3)
12	Unplanned revascularisation
13	Acute renal failure
14	Thrombocytopaenia

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Cardiogenic shock

Use this code when the person has experienced cardiogenic shock, including if the person was in shock at the time of presentation to the hospital.

Cardiogenic shock is defined as:

- hypotension (systolic BP <90mmHg for at least 30 minutes or

the need for supportive measures to maintain blood pressure of greater than or equal to 90mmHg)

- end-organ hypoperfusion (cool extremities or a urine output of <30ml/hour, and a heart rate ≥60 beats/minute)

- a cardiac index of no more than 2.2 l/min per square meter of body-surface area and a pulmonary-capillary wedge pressure of at least 15 mmHg.

CODE 2 Cardiac rupture

Use this code when the person has a rupture of the ventricular myocardium, the ventricular septum, or a frank papillary muscle rupture. This includes if the person experienced the rupture before presentation to the hospital.

CODE 3 Cardiac arrest

Use this code when the person has experienced cardiac arrest (i.e. the lack of effective cardiac output), including if the person was under arrest at the time of presentation to the hospital.

CODE 4 New or recurrent myocardial infarction

Use this code when the person experiences a myocardial infarction during hospitalisation distinct from the index event at the time of presentation.

Recurrent myocardial infarction is defined by clinical events and cardiac marker elevations after the first 24 hours following presentation to the hospital.

For people presenting without initial evidence of myonecrosis, recurrent MI is defined by:

- A rise in troponin T or I to greater than the diagnostic threshold level (with precision of 10% coefficient of variation) as defined by the local laboratory; OR

- A CK-MB elevation of greater than twice the upper limit of normal for the laboratory (if CK-MB is not available, CK may be used).

For people presenting with evidence of myonecrosis:

- A further rise in troponin of greater than 25% or a re-elevation in CK-MB of greater than 50% (if no CK-MB is drawn, CK may be used) will define recurrent MI

- If the event occurs within 24 hours of PCI, then a level of greater than 3 times the upper limit of normal for CK-MB will be used. If the event occurs within 24 hours of CABG, then a level of greater than 5 times the upper limit of normal for CK-MB will be used.

CODE 5 Stroke

Use this code if the person experiences a loss of neurological function with residual symptoms remaining for at least 24 hours after onset and which occurred before presentation to the hospital. The occurrence of stroke should be evidenced by a record of cerebral imaging (CT or MRI).

CODE 6 Acute pulmonary oedema/congestive heart failure

Use this code when the person has experienced acute pulmonary oedema or congestive heart failure with evidence of supportive clinical signs of ventricular dysfunction. These include:

- Third heart sound (S3)

- Cardiomegaly

- Elevated jugular venous pressure (JVP)

- Chest X-ray evidence of pulmonary congestion

- Requirement for ventilatory assistance (CPAP or intubation).

This includes if acute pulmonary oedema or congestive heart failure was present at the time of presentation to the hospital.

CODE 7 Recurrent rest angina with electrocardiogram (ECG) changes

Use this code when the person has experienced recurrent ischaemic pain occurring at rest believed to be cardiac in origin with associated ECG changes.

CODE 8 Recurrent rest angina without electrocardiogram (ECG) changes

Use this code when the person has experienced recurrent ischaemic pain occurring at rest believed to be cardiac in origin without associated ECG changes.

CODE 9 New onset arrhythmia: atrial

Use this code when the person has experienced an atrial arrhythmia, that was not present before this acute coronary syndrome event, documented by one of the following:

- Atrial fibrillation/flutter

- Supraventricular tachycardia requiring treatment (i.e. requiring cardioversion, drug therapy, or is sustained for greater than one minute).

CODE 10 New onset arrhythmia: ventricular

Use this code when the person has experienced ventricular tachycardia or ventricular fibrillation requiring cardioversion and/or intravenous antiarrhythmics, that was not present before this acute coronary syndrome event.

CODE 11 New onset arrhythmia: heart block (1,2,3)

Use this code when the person has experienced first, second or third degree atrioventricular block with bradycardia with or without the requirement for pacing.

CODE 12 Unplanned revascularisation

Use this code when the person has undergone revascularisation precipitated by 20 minutes or more of recurrent chest pain with/or without objective evidence of ischaemia on the ECG.

Code 13 Acute renal failure

Use this code when the person has acute renal failure as determined by a rise in serum creatinine of x 1.5 or a decrease in GFR by 25% or urine output <0.5mL/kg/h for 6 hours.

Code 14 Thrombocytopenia

Use this code when the person has thrombocytopenia as determined by the platelet count: platelet count dropped to less than 100 x 10^9/L.

Data element attributes

Collection and usage attributes

Guide for use:

Record all clinical events that the person experiences from the time of presentation to hospital until discharge from hospital.

More than one event may be recorded.

The time and date must be recorded for each clinical event that occurs.

Comments:

An acute coronary syndrome (ACS) related clinical event is a

clinical event which can affect the health outcomes of a person with ACS.

Information on the occurrence of these clinical events in people with ACS is required due to an emerging appreciation of their relationship with late mortality.

Source and reference attributes

Reference documents: Chew DPB et al. National data elements for the clinical management of acute coronary syndromes. Medical Journal of Australia. Volume 182 Number 9. 2 May 2005.

Relational attributes

Implementation in Data Set Specifications: Acute coronary syndrome clinical event cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation: If a clinical event has occurred, record the clinical event type.

Information specific to this data set: Codes are to be provided for each clinical event prescribed during this hospital presentation.

Person with acute coronary syndrome—underlying cause of acute coronary syndrome, code N

Identifying and definitional attributes

Short name:	Other/Underlying cause of acute coronary syndrome
Synonymous names:	Secondary cause of ACS
METeOR identifier:	338310
Registration status:	Health, Standard 01/10/2008
Definition:	The condition or event, other than the usual risk factors, which has caused a person's acute coronary syndrome symptoms, as represented by a code
Data Element Concept:	Person—underlying cause of acute coronary syndrome

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	9

Permissible values:

Value	Meaning
1	Anaemia
2	Severe valvular disease
3	Thyrotoxicosis
4	Fever
5	Hypoxaemia
6	Trauma
7	Surgery

Supplementary values:

88	Other
99	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Collection methods:	This is to be recorded by the clinician.
Comments:	This identifies whether the person experiencing acute coronary syndrome (ACS) symptoms is doing so due to another condition or event and where the treatment would be primarily targeted at managing that condition. The presence of one of these conditions or events has a significant impact on the appropriate treatment modalities for ACS. Therefore, the person's treatment may be different from those recommended for ACS.

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Person—acute coronary syndrome procedure type, code NN

Identifying and definitional attributes

Metadata item type:	Data Element
Short name:	Acute coronary syndrome procedure type
METeOR identifier:	356659
Registration status:	Health, Standard 01/10/2008
Definition:	The type of procedure performed, that is pertinent to the treatment of acute coronary syndrome, as represented by a code.
Data Element Concept:	Person—acute coronary syndrome procedure type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
01	Coronary artery bypass graft (CABG)
05	Reperfusion: fibrinolytic therapy
06	Reperfusion: primary percutaneous coronary intervention (PCI)
07	Reperfusion: rescue percutaneous coronary intervention (PCI)
08	Vascular reconstruction, bypass surgery, or percutaneous intervention to the extremities or for aortic aneurysm
09	Amputation for arterial vascular insufficiency
10	Diagnostic cardiac catheterisation/angiography
11	Blood transfusion
12	Insertion of pacemaker
13	Implantable cardiac defibrillator
14	Intra-aortic balloon pump (IABP)
15	Non-invasive ventilation (CPAP)
16	Invasive ventilation
17	Defibrillation
18	Revascularisation: percutaneous coronary intervention (PCI)
19	Pulmonary artery (Swan Ganz) catheter
88	Other

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Source and reference attributes

Data element attributes

Collection and usage attributes

Guide for use:

More than one procedure can be recorded. Record all codes that apply.

Codes '88' and '99' in combination cannot be used in multiple entries.

CODE 06 Reperfusion: primary percutaneous coronary intervention (PCI)

Primary PCI relates to balloon angioplasty and/or stent implantation for reperfusion therapy of a ST-segment-elevation myocardial infarction (STEMI).

CODE 07 Reperfusion: rescue percutaneous coronary intervention (PCI)

Rescue PCI relates to a balloon angioplasty and/or stent implantation that is performed following failed fibrinolysis in people with continuing or recurrent myocardial ischaemia.

CODE 18 Revascularisation: percutaneous coronary intervention (PCI)

Revascularisation PCI relates to the restoration of blood flow through balloon angioplasty and/or stent implantation outside the setting of myocardial salvage for STEMI. Revascularisation PCI may be performed on a person following STEMI where there is objective evidence of spontaneous or inducible ischaemia or hameodynamic instability. Revascularisation PCI may also be performed on a person with high-risk non-ST-segment-elevation acute coronary syndrome.

When read in conjunction with Person—clinical procedure timing, code N, this metadata item provides information on the procedure(s) provided to a patient prior to or during this presentation.

When read in conjunction with Person—acute coronary syndrome risk stratum, code N, codes 01, 05, 06, 07, 08, 09, 10 and 18 of this metadata item provide information for risk stratification.

Where codes 06, 07 and 18 have been recorded please also record Person - percutaneous coronary intervention procedure, code N.

Collection methods:

For each Person-acute coronary syndrome procedure type, code NN, the following timing data elements must also be recorded, where applicable:

- Person - clinical procedure timing, code N
- Person - intravenous fibrinolytic therapy date, DDMMYYYY
- Person - intravenous fibrinolytic therapy time, hhmm
- Person - primary percutaneous coronary intervention date, DDMMYYYY
- Person - primary percutaneous coronary intervention time, hhmm
- Person - rescue percutaneous coronary intervention date, DDMMYYYY
- Person - rescue percutaneous coronary intervention time,

hhmm

- Person - revascularisation percutaneous coronary intervention date, DDMMYYYY
- Person - revascularisation percutaneous coronary intervention time, hhmm
- Person - pacemaker insertion date, DDMMYYYY
- Person - pacemaker insertion time, hhmm
- Person - implantable cardiac defibrillator procedure date, DDMMYYYY
- Person - implantable cardiac defibrillator procedure time, hhmm
- Person - intra-aortic balloon pump procedure date, DDMMYYYY
- Person - intra-aortic balloon pump procedure time, hhmm
- Person - non-invasive ventilation administration date, DDMMYYYY
- Person - non-invasive ventilation administration time, hhmm

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Person—acute coronary syndrome procedure type, code NN Health, Superseded 01/10/2008 See also Person—clinical procedure timing, code N Health, Standard 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Person—acute coronary syndrome related medical history, code NN

Identifying and definitional attributes

Short name:	Acute coronary syndrome related medical history
METeOR identifier:	356598
Registration status:	Health, Standard 01/10/2008
Definition:	A person's history of acute coronary syndrome related medical conditions as represented by a code.
Data Element Concept:	Person—acute coronary syndrome related medical history

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
11	Angina (excluding unstable angina): prior existing
12	Angina (excluding unstable angina): new onset
13	Unstable angina
21	Chronic lung disease
31	Heart failure
41	Hypertension
51	Ischaemic: non-haemorrhagic cerebral infarction
52	Haemorrhagic: intracerebral haemorrhage
61	Peripheral artery disease
62	Aortic aneurysm
63	Renal artery stenosis
71	Sleep apnoea
81	Previous myocardial infarction
91	Atrial fibrillation
92	Other dysrhythmia or conductive disorder
93	Left ventricular hypertrophy

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Angina:

CODE 11 Angina (excluding unstable angina): prior existing

This code is used where there are symptoms, which can be described as chest pain or pain in either or both shoulders, the back, neck or jaw, or other equivalent discomfort (such as tightness, gripping or squeezing) suggestive of cardiac

ischaemia, the onset of which occured more than two weeks ago.

CODE 12 Angina (excluding unstable angina): new onset

This code is used where there are symptoms, which can be described as chest pain or pain in either or both shoulders, the back, neck or jaw, or other equivalent discomfort (such as tightness, gripping or squeezing) suggestive of cardiac ischaemia,the onset of which occured two or less weeks ago.

CODE 13 Unstable angina

This code is used where a person has experienced new onset or prior existing angina (described as chest pain or pain in either or both shoulders, the back, neck or jaw, or other equivalent discomfort (such as tightness, gripping or squeezing)) which is increasing in severity, duration or frequency.

Chronic lung disease:

CODE 21 Chronic lung disease

This code is used where there is a history or symptoms suggestive of chronic lung disease.

Heart failure:

CODE 31 Heart failure

This code is used where a person has past or current symptoms of heart failure (typically breathlessness or fatigue), either at rest or during physical activity and/or signs of pulmonary or peripheral congestion suggestive of cardiac dysfunction.

Hypertension:

CODE 41 Hypertension

This code is used where there is current use of pharmacotherapy for hypertension and/or clinical evidence of high blood pressure.

CODE 51 Ischaemic: non-haemorrhagic cerebral infarction

This code is used if there is history of stroke or cerebrovascular accident (CVA) resulting from an ischaemic event where the patient suffered a loss of neurological function with residual symptoms remaining for at least 24 hours.

CODE 52 Haemorrhagic: intracerebral haemorrhage

This code is used if there is history of stroke or cerebrovascular accident (CVA) resulting from a haemorrhagic event where the patient suffered a loss of neurological function with residual symptoms remaining for at least 24 hours.

Peripheral arterial disease:

CODE 61 Peripheral artery disease

This code is used where there is history of either chronic or acute occlusion or narrowing of the arterial lumen in the aorta or extremities.

CODE 62 Aortic aneurysm

This code is used where there is a history of aneurysmal dilatation of the aorta (thoracic and or abdominal).

CODE 63 Renal artery stenosis

This code is used where there is a history of functional stenosis of one or both renal arteries.

Sleep apnoea syndrome:

CODE 71 Sleep apnoea

This code is used where there is evidence of sleep apnoea syndrome (SAS) on history.

Myocardial infarction:

CODE 81 Previous myocardial infarction

This code is used where a person has previously experienced a myocardial infarction, excluding the current event that prompted this presentation to hospital. This may be supported by clinical documentation and evidenced by ECG changes or serum cardiac biomarker changes.

Other vascular conditions:

CODE 91 Atrial fibrillation

This code is used where there is a history or symptoms suggestive of atrial fibrillation.

CODE 92 Other cardiac arrhythmias or conductive disorders

This code is used where there is a history of other cardiac arrhythmias or conductive disorders.

CODE 93 Left ventricular hypertrophy

This code is used where there is a history or symptoms suggestive of left ventricular hypertrophy.

Data element attributes

Collection and usage attributes

Guide for use:	More than one medical condition may be recorded. Record only those codes that apply. Record all codes that apply.
Collection methods:	Where codes 21, 31, 51, 52, 61, 62, 63, 71, 91, 92 and 93 are recorded Person - clinical evidence status (acute coronary syndrome related medical conditions), yes/no code N must also be recorded.
Comments:	A history of the listed medical conditions is pertinent to the risk stratification and treatment of acute coronary syndrome.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Reference documents:	National Heart Foundation of Australia & Cardiac Society of Australia and New Zealand. Guidelines for the management of acute coronary syndromes 2006. Med J Aust 2006; 184; S1-S32. © MJA 2006

Relational attributes

Related metadata references:	Supersedes Person—acute coronary syndrome concurrent clinical condition, code NN Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Person—acute coronary syndrome risk stratum, code N

Identifying and definitional attributes

Short name:	Acute coronary syndrome stratum
METeOR identifier:	356665
Registration status:	Health, Standard 01/10/2008
Definition:	Risk stratum of a person presenting with clinical features consistent with an acute coronary syndrome defined by accompanying clinical, electrocardiogram (ECG) and biochemical features, as represented by a code.
Data Element Concept:	Person—acute coronary syndrome risk stratum

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	ST-segment-elevation (myocardial infarction)
2	Non-ST-segment-elevation ACS with high-risk features
3	Non-ST-segment-elevation ACS with intermediate-risk features
4	Non-ST-segment-elevation ACS with low-risk features
Supplementary values: 9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 ST-segment-elevation (myocardial infarction)

This code is used where persistent ST elevation of >=1mm in two contiguous limb leads, or ST elevation of >=2mm in two contiguous chest leads, or with new left bundle -branch block (BBB) pattern on the ECG.

This classification is intended for identification of patients potentially eligible for reperfusion therapy, either pharmacologic or intervention-based. Other considerations such as the time to presentation and the clinical appropriateness of instituting reperfusion are not reflected in this metadata item.

CODE 2 Non-ST-segment-elevation ACS with high-risk features

This code is used when presentation with clinical features consistent with an acute coronary syndrome with high-risk features which include any of the following:

- repetitive or prolonged (> 10 minutes) ongoing chest pain or discomfort;
- elevated level of at least one cardiac biomarker (troponin or creatine kinase-MB isoenzyme);

- persistent or dynamic ECG changes of ST segment depression >= 0.5mm or new T wave >= 2mm;
- transient ST-segment elevation (>= 0.5 mm) in more than 2 contiguous leads;
- haemodynamic compromise: Blood pressure < 90 mmHg systolic, cool peripheries, diaphoresis, Killip Class > 1, and/or new onset mitral regurgitation;
- sustained ventricular tachycardia;
- syncope;
- left ventricular systolic dysfunction (left ventricular ejection fraction < 0.40);
- prior percutaneous coronary intervention within 6 months or prior coronary artery bypass surgery;
- presence of known diabetes (with typical symptoms of ACS);or
- chronic kidney disease (estimated glomerular filtration rate < 60mL/minute) (with typical symptoms of ACS).

This classification is intended for identification of patients potentially eligible for aggressive medical management and coronary angiography and revascularisation.

CODE 3 Non-ST-segment-elevation ACS with intermediate-risk features

This code is used when presentation with clinical features consistent with an acute coronary syndrome and any of the following intermediate-risk features AND NOT meeting the criteria for high-risk ACS:

- chest pain or discomfort within the past 48 hours that occurred at rest, or was repetitive or prolonged (but currently resolved);
- age greater than 65yrs;
- known coronary heart disease: prior myocardial infarction with left ventricular ejection fraction >= 0.40 known coronary lesion more than 50% stenosed;
- no high-risk changes on electrocardiography (see high-risk features);
- two or more of the following risk factors:known hypertension, family history, active smoking or hyperlipidaemia;
- presence of known diabetes (with atypical symptoms of ACS);
- chronic kidney disease (estimated glomerular filtration rate < 60mL/minute) (with atypical symptoms of ACS); or
- prior aspirin use.

This classification is intended for identification of patients potentially eligible for accelerated diagnostic evaluation and further risk stratification.

CODE 4 Non-ST-segment-elevation ACS with low-risk features

This code is used when presentation with clinical features consistent with an acute coronary syndrome without intermediate or high-risk features of non-ST-segment-elevation ACS. This includes onset of anginal symptoms within the last month, or worsening in severity or frequency of angina, or lowering of anginal threshold.

This classification is intended for identification of patients potentially eligible for outpatient investigation discharge on upgraded medical therapy and outpatient investigation.

Data element attributes

Collection and usage attributes

Guide for use:

Other clinical considerations influencing the decision to admit and investigate are not reflected in this metadata item. This metadata item is intended to simply provide a diagnostic classification at the time of, or within hours of clinical presentation.

Acute coronary syndrome symptoms may include:

- tightness, pressure, heaviness, fullness or squeezing in the chest which may spread to the neck and throat, jaw, shoulders, the back, upper abdomen, either or both arms and even into the wrists and hands
- dyspnoea, nausea/vomiting, cold sweat or syncope.

Collection methods:

Recorded at time of presentation.

Only one code should be recorded.

Must be recorded in conjunction with Person—acute coronary syndrome procedure type, code NN and Person—clinical procedure timing, code N.

Comments:

The clinical, electrocardiogram and biochemical characteristics are important to enable early risk stratification.

Source and reference attributes

Submitting organisation:

Acute coronary syndrome data working group

Origin:

National Heart Foundation of Australia & Cardiac Society of Australia and New Zealand. Guidelines for the management of acute coronary syndromes 2006. Med J Aust 2006; 184; S1-S32. © MJA 2006

The TIMI Risk Score for Unstable Angina/Non-ST Elevation MI JAMA. 2000; 284:835-842.

Relational attributes

Related metadata references:

Supersedes Person—acute coronary syndrome risk stratum, code N Health, Superseded 01/10/2008

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Person—acute coronary syndrome symptoms onset date, DDMMYYYY

Identifying and definitional attributes

Short name:	Date of onset of acute coronary syndrome symptoms
Synonymous names:	Date of onset of ACS symptoms
METeOR identifier:	321201
Registration status:	Health, Standard 01/10/2008
Definition:	The date on which a person experienced acute coronary syndrome symptoms that prompted the person to seek medical attention, either at the hospital or from a general practitioner.
Data Element Concept:	Person—acute coronary syndrome symptoms onset date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

Acute coronary syndrome symptoms may include:

- tightness, pressure, heaviness, fullness or squeezing in the chest which may spread to the neck and throat, jaw, shoulders, the back, upper abdomen, either or both arms and even into the wrist and hands
- dyspnoea, nausea/vomiting, cold sweat or syncope.

Seeking medical attention could include the person presenting to their GP who then refers them to hospital or the person presenting directly to hospital (via ambulance or own form of transport).

If the person is already a patient at the hospital for another reason then the date would be when they advised hospital staff of their symptoms.

Collection methods:

Record the date that the person identifies as being when the most significant acute coronary syndrome symptom/s occurred that prompted them to seek medical attention.

Relational attributes

Related metadata references:

See also Person—acute coronary syndrome risk stratum, code N Health, Superseded 01/10/2008

See also Person—acute coronary syndrome symptoms onset time, hhmm Health, Standard 01/10/2008

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Person—acute coronary syndrome symptoms onset time, hhmm

Identifying and definitional attributes

Short name:	Time of onset of acute coronary syndrome symptoms
METeOR identifier:	321211
Registration status:	Health, Standard 01/10/2008
Definition:	The time at which a person experienced acute coronary syndrome symptoms that prompted a person to seek medical attention, either at the hospital or from a general practitioner.
Data Element Concept:	Person—acute coronary syndrome symptoms onset time

Value domain attributes

Representational attributes

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

Source and reference attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

Acute coronary syndrome symptoms may include:

- tightness, pressure, heaviness, fullness or squeezing in the chest which may spread to the neck and throat, jaw, shoulders, the back, upper abdomen, either or both arms and even into the wrists and hands
- dyspnoea, nausea/vomiting, cold sweat or syncope.

Seeking medical attention could include the person presenting to their GP who then refers them to hospital or the person presenting directly to hospital (via ambulance or own form of transport).

If the person is already a patient at the hospital for another reason then the time recorded would be when they advised hospital staff of their symptoms.

Collection methods:

Record the time of onset of the most significant acute coronary syndrome symptom/s that prompted the person to seek medical attention (from the person's perspective).

Relational attributes

Related metadata references:	See also Person—acute coronary syndrome symptoms onset date, DDMMYYYY Health, Standard 01/10/2008
Implementation in Data Set	Acute coronary syndrome (clinical) DSS Health, Standard

Specifications: 01/10/2008

Person—angina episodes count (24 hours preceding hospital presentation), total number NN[N]

Identifying and definitional attributes

Short name:	Number of episodes of angina in last 24 hours
METeOR identifier:	338293
Registration status:	Health, Standard 01/10/2008
Definition:	The number of angina episodes experienced by a person in the 24 hours preceding presentation to the hospital, including the current episode.
Data Element Concept:	Person—count of angina episodes

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
999	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	Is the total number of distinct episodes of anginal pain that occurred in the 24 hours preceding presentation to the hospital, including the current episode for which the person presented to hospital. An episode of angina may include chest pain (which may spread to either or both shoulders, the back, neck, jaws or down the arm) or overwhelming shortness of breath.
Collection methods:	Ask the individual how many distinct episodes of anginal pain he/she experienced in the 24 hours preceding presentation to hospital, including the current episode. Alternatively, if available, obtain this information from appropriate documentation.

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Person—angina status, Canadian Cardiovascular Society code N

Identifying and definitional attributes

Short name:	Angina status
METeOR identifier:	338335
Registration status:	Health, Standard 01/10/2008
Definition:	The limitation of physical activity experienced by a person with the onset of angina, as represented by the Canadian Cardiovascular Society code.
Data Element Concept:	Person—angina status

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	No angina with ordinary physical activity
2	Slight limitation of ordinary physical activity
3	Marked limitation of ordinary physical activity
4	Inability for any physical activity without anginal symptoms

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Code 1 No angina with ordinary physical activity

Use this code for patients who have no angina on ordinary physical activity such as walking or stair climbing. Angina occurs with strenuous, rapid or prolonged exertion at work or recreation.

Code 2 Slight limitation of ordinary physical activity

Use this code for patients for whom angina occurs on walking or climbing stairs rapidly, walking uphill, walking or climbing stairs after a meal, or under emotional stress, or in the cold, or only during the first few hours after waking.

Code 3 Marked limitation or ordinary physical activity

Use this code for patients where angina occurs walking one or two blocks on the level and climbing one or more flights of stairs in normal conditions and at a normal pace.

Code 4 Inability for any physical activity without anginal symptoms

Use this code for patients who are unable to carry on any physical activity without discomfort - anginal symptoms may be present at rest.

Collection methods: Angina status is self-reported by the person but is interpreted, coded and recorded by the health professional.

Data element attributes

Relational attributes

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Data set specification specific attributes

Information specific to this data set: This is the status of angina that a person experiences following discharge from hospital.

Person—bleeding episode status, Thrombolysis in Myocardial Infraction (TIMI) code N

Identifying and definitional attributes

Short name:	Bleeding episode using TIMI criteria (status)
METeOR identifier:	356725
Registration status:	Health, Standard 01/10/2008
Definition:	A person's episode of bleeding as described by the Thrombolysis In Myocardial Infarction (TIMI) criteria, as represented by a code.
Data Element Concept:	Person—bleeding episode status

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Major
	2	Minor
	3	Non TIMI bleeding
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Note in calculating the fall in haemoglobin or haematocrit, transfusion of whole blood or packed red blood cells is counted as 1g/dl (0.1g/l) haemoglobin or 3% absolute haematocrit.

CODE 1 Major

Overt clinical bleeding (or documented intracranial or retroperitoneal haemorrhage) associated with a drop in haemoglobin of greater than 5g/dl (0.5g/l) or a haematocrit of greater than 15% (absolute).

CODE 2 Minor

Overt clinical bleeding associated with a fall in haemoglobin of 3 or less than or equal to 5g/dl (0.5g/l) or a haematocrit of 9% to less than or equal to 15% (absolute).

CODE 3 Non TIMI Bleeding

Bleeding event that does not meet the major or minor definition.

Data element attributes

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group
Origin:	Rao AK, Pratt C, Berke A, et al. Thrombolysis in Myocardial Infarction (TIMI) Trial, phase I: hemorrhagic manifestations and

changes in plasma fibrinogen and the fibrinolytic system in patients with recombinant tissue plasminogen activator and streptokinase. J Am Coll Cardiol 1988; 11:1-11.

Relational attributes

Related metadata references:	Supersedes Person—bleeding episode status, code N Health, Superseded 01/10/2008 See also Person with acute coronary syndrome—bleeding location, instrumented code N(N) Health, Standard 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Person—C-reactive protein level (measured), total milligrams per litre N[NN].N

Identifying and definitional attributes

Short name:	C-reactive protein level (measured)
Synonymous names:	CRP measured
METeOR identifier:	338256
Registration status:	Health, Standard 01/10/2008
Definition:	A person's serum C-reactive protein (CRP) level, measured in milligrams per litre.
Data Element Concept:	Person—C-reactive protein level (measured)

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
999.9	Not stated/inadequately described

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

Data element attributes

Collection and usage attributes

Comments: The value should be recorded on a high sensitivity assay.

CRP is used in the assessment of acute phase reaction in inflammatory, infective and neoplastic disorders.

Source and reference attributes

Reference documents: The Royal College of Pathologists of Australia Version 4.0 12th March 2004 (last accessed 12May 2006). http://www.rcpamanual.edu.au/sections/pathologytest.asp?s=33&i=468

Relational attributes

Related metadata references: See also Person—C-reactive protein level measured time, hhmm Health, Standard 01/10/2008

See also Person—C-reactive protein level measured date, DDMMYYYY Health, Standard 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Data set specification specific attributes

Information specific to this data set:	The C-reactive protein (CRP) level should be measured as early as possible following presentation to the hospital.

Person—C-reactive protein level measured date, DDMMYYYY

Identifying and definitional attributes

Short name:	Date C-reactive protein level measured
Synonymous names:	CRP measured date
METeOR identifier:	338280
Registration status:	Health, Standard 01/10/2008
Definition:	The date a person's C-reactive protein (CRP) level is measured.
Data Element Concept:	Person—C-reactive protein level measured date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Collection methods:	The date C-reactive protein (CRP) is measured should be recorded from the laboratory report.

Relational attributes

Related metadata references:	See also Person—C-reactive protein level measured time, hhmm Health, Standard 01/10/2008 See also Person—C-reactive protein level (measured), total milligrams per litre N[NN].N Health, Standard 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Data set specification specific attributes

Information specific to this data set:	The date of C-reactive protein (CRP) measurement recorded should be after or the same as the date of onset of ACS symptoms.

Person—C-reactive protein level measured time, hhmm

Identifying and definitional attributes

Short name:	Time C-reactive protein level measured
Synonymous names:	CRP measured time
METeOR identifier:	343853
Registration status:	Health, Standard 01/10/2008
Definition:	The time the person's C-reactive protein (CRP) level is measured.
Data Element Concept:	Person—C-reactive protein level measured time

Value domain attributes

Representational attributes

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

Source and reference attributes

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

Data element attributes

Collection and usage attributes

Collection methods:	The time C-reactive protein (CRP) is measured should be recorded from the laboratory report.

Relational attributes

Related metadata references:	See also Person—C-reactive protein level (measured), total milligrams per litre N[NN].N Health, Standard 01/10/2008 See also Person—C-reactive protein level measured date, DDMMYYYY Health, Standard 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Person—chest pain pattern, code N

Identifying and definitional attributes

Short name:	Chest pain pattern category
METeOR identifier:	356738
Registration status:	Health, Standard 01/10/2008
Definition:	The person's chest pain pattern, as represented by a code.
Data Element Concept:	Person—chest pain pattern

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Atypical chest pain
2	Stable chest pain pattern
3	Unstable chest pain pattern: rest &/or prolonged
4	Unstable chest pain pattern: new & severe
5	Unstable chest pain pattern: accelerated & severe

Supplementary values:

Value	Meaning
9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Chest pain or discomfort of myocardial ischaemic origin is usually described as pain, discomfort or pressure in the chest or the upper body (neck and throat, jaw, shoulders, back, either or both arms, wrists and hands) or other equivalent discomfort suggestive of cardiac ischaemia. Ask the person when the symptoms first occurred or obtain this information from appropriate documentation.

CODE 1 Atypical chest pain

Use this code for pain, pressure, or discomfort in the chest, or upper body not clearly exertional or not otherwise consistent with pain or discomfort of myocardial ischaemic origin.

CODE 2 Stable chest pain pattern

Use this code for chest pain without a change in frequency or pattern for the 6 weeks before this presentation or procedure. Chest pain is controlled by rest and/or sublingual/oral/transcutaneous medications.

CODE 3 Unstable chest pain pattern: rest and/or prolonged

Use this code for chest pain that occurred at rest and was prolonged, usually lasting for at least 10 minutes

CODE 4 Unstable chest pain pattern: new and severe

Use this code for new-onset chest pain that could be described as at least Canadian Cardiovascular Society (CCS) classification

3 severity.

CODE 5 Unstable chest pain pattern: accelerated and severe

Use this code for recent acceleration of chest pain pattern that could be described by an increase in severity of at least 1 CCS class to at least CCS class 3.

Data element attributes

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Relational attributes

Related metadata references: Supersedes Person—chest pain pattern, code N Health, Superseded 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Data set specification specific attributes

Information specific to this data set: The Canadian Cardiovascular Society classes of angina can be used to support categorisation of chest pain patterns. Canadian Cardiovascular Society (CCS) classes of angina (Campeau L. Grading of angina pectoris. Circulation 1976; 54:522.)

1. Ordinary physical activity (for example, walking or climbing stairs) does not cause angina; angina occurs with strenuous or rapid or prolonged exertion at work or recreation.
2. Slight limitation of ordinary activity (for example, angina occurs walking or stair climbing after meals, in cold, in wind, under emotional stress, or only during the few hours after awakening; walking more than 2 blocks on the level or climbing more than 1 flight of ordinary stairs at a normal pace; and in normal conditions).
3. Marked limitation of ordinary activity (for example, angina occurs with walking 1 or 2 blocks on the level or climbing 1 flight of stairs in normal conditions and at a normal pace).
4. Inability to perform any physical activity without discomfort; angina syndrome may be present at rest.

Person—cholesterol level (measured), total millimoles per litre N[N].N

Identifying and definitional attributes

Short name:	Cholesterol—total (measured)
METeOR identifier:	359245
Registration status:	Health, Standard 01/10/2008
Definition:	A person's total cholesterol (TC), measured in millimoles per litre.
Data Element Concept:	Person—cholesterol level

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
99.9	Not stated/inadequately described.

Unit of measure:	Millimole per litre (mmol/L)

Data element attributes

Collection and usage attributes

Guide for use:

Measurement in mmol/L to 1 decimal place.

Record the absolute result of the total cholesterol measurement. When reporting, record whether or not the measurement of Cholesterol-total - measured was performed in a fasting specimen.

Collection methods:

When reporting, record absolute result of the most recent Cholesterol-total - measured in the last 12 months to the nearest 0.1 mmol/L.

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

- To be collected as a single venous blood sample, preferably following a 12-hour fast where only water and medications have been consumed.
- Prolonged tourniquet use can artefactually increase levels by up to 20%.

Comments:

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

High blood cholesterol is a key factor in heart, stroke and vascular disease, especially coronary heart disease.

Poor nutrition can be a contributing factor to heart, stroke and

vascular disease as a population's level of saturated fat intake is the prime determinant of its level of blood cholesterol.

Large clinical trials have shown that people at highest risk of cardiovascular events (e.g. pre-existing ischaemic heart disease) will derive the greatest benefit from lipid lowering drugs.Recent trials have suggested that there should be no cholesterol level threshold for the initiation of treatment in tis group of patients. In October 2006, the PBS criteria for lipid-lowering drugs was expanded to include all patients identified as high-risk (based on PBs criteria) regardless of their cholesterol level.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Origin: National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand, Lipid Management Guidelines - 2001, MJA 2001; 175: S57-S88

National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand, Position Statement on Lipid Management - 2005, Heart Lung and Circulation 2005; 14: 275-291.

National Health Priority Areas Report: Cardiovascular Health 1998. AIHW Cat. No. PHE 9. HEALTH and AIHW, Canberra.

The Royal College of Pathologists of Australasia web based Manual of Use and Interpretation of Pathology Tests. Version 4.0.

Relational attributes

Related metadata references: Supersedes Person—cholesterol level (measured), total millimoles per litre N[N].N Health, Superseded 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Person—clinical evidence status (acute coronary syndrome related medical history), yes/no code N

Identifying and definitional attributes

Short name:	Clinical evidence of acute coronary syndrome related medical history
METeOR identifier:	356777
Registration status:	Health, Standard 01/10/2008
Definition:	An indicator of whether there is objective evidence for a person's history of an acute coronary syndrome related medical condition, as represented by a code.
Data Element Concept:	Person—clinical evidence status (acute coronary syndrome related medical history)

Value domain attributes

Representational attributes

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

Collection and usage attributes

Guide for use:

CODE 9 Not stated/inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes

Use this code where there is objective evidence to support a history of an acute coronary syndrome related medical condition.

CODE 2 No

Use this code where the history is not supported by objective evidence.

Objective evidence for acute coronary syndrome related medical conditions are classified as:

Chronic lung disease:

Diagnosis supported by current use of chronic lung disease pharmacological therapy (e.g. inhalers, theophylline, aminophylline, or steroids), or a forced expiratory volume in 1 second (FEV1) less than 80% predicted FEV1/forced vital capacity (FVC) less than 0.7 (post bronchodilator). Respiratory failure partial pressure of oxygen (PaO2) less than 60 mmHg

(8kPa), or partial pressure of carbon dioxide (PaCO2) greater than 50 mmHg (6.7 kPa).

Heart failure:

Current symptoms of heart failure (typically shortness of breath or fatigue), either at rest or during exercise and/or signs of pulmonary or peripheral congestion and objective evidence of cardiac dysfunction at rest. The diagnosis is derived from and substantiated by clinical documentation from testing according to current practices.

Stroke:

Diagnosis for ischaemic: non-haemorrhagic cerebral infarction or haemorrhagic: intracerebral haemorrhage supported by cerebral imaging (CT or MRI).

Peripheral arterial disease:

- Peripheral artery disease: diagnosis is derived from and substantiated by clinical documentation for a person with a history of either chronic or acute occlusion or narrowing of the arterial lumen in the aorta or extremities.
- Aortic aneurysm: diagnosis of aneurysmal dilatation of the aorta (thoracic and or abdominal) supported and substantiated by appropriate documentation of objective testing.
- Renal artery stenosis: diagnosis of functional stenosis of one or both renal arteries is present and is supported and substantiated by appropriate documentation of objective testing.

Sleep apnoea:

Diagnosis derived from and substantiated by clinical documentation of sleep apnoea syndrome (SAS). SAS has been diagnosed from the results of a sleep study.

Other vascular conditions:

- Atrial fibrillation: diagnosis supported by electrocardiogram findings.
- Other cardiac arrhythmias and conductive disorders: diagnosis supported by electrocardiogram findings.
- Left ventricular hypertrophy: diagnosis supported by echocardiograph evidence.

Collection methods:

For each of the following medical conditions the clinical evidence status must also be recorded:

- Chronic lung disease
- Heart failure
- Stroke
- Peripheral arterial disease
- Sleep apnoea syndrome
- Other vascular conditions

Comments:

Heart failure:

Chronic heart failure is a complex clinical syndrome with typical symptoms (e.g. shortness of breath, fatigue) that can occur at rest or on effort, and is characterised by objective evidence of an underlying structural abnormality of cardiac dysfunction that impairs the ability of the ventricle to fill with or eject blood (particularly during physical activity).

The most widely available investigation for documenting left ventricular dysfunction is the transthoracic echocardiogram

(TTE).
Other modalities include:

- transoesophageal echocardiography (TOE)
- gated radionuclide angiocardiography
- angiographic left ventriculography

In the absence of any adjunctive laboratory tests, evidence of supportive clinical signs of ventricular dysfunction. These include:

- cardiac auscultation (S3, cardiac murmurs),
- cardiomegaly,
- elevated jugular venous pressure (JVP),
- chest X-ray evidence of pulmonary congestion

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Reference documents: The Thoracic Society of Australia & New Zealand and the Australian Lung Foundation, Chronic Obstructive Pulmonary Disease (COPD) Australian & New Zealand Management Guidelines and the COPD Handbook. Version 1, November 2002.

National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand (Chronic Heart Failure Guidelines Expert Writing Panel). Guidelines for the prevention, detection and management of chronic heart failure in Australia, 2006.

Relational attributes

Related metadata references: Supersedes Person—clinical evidence status (chronic lung disease), code N Health, Superseded 01/10/2008

Supersedes Person—clinical evidence status (heart failure), code N Health, Superseded 01/10/2008

Supersedes Person—clinical evidence status (peripheral arterial disease), code N Health, Superseded 01/10/2008

Supersedes Person—clinical evidence status (sleep apnoea syndrome), code N Health, Superseded 01/10/2008

Supersedes Person—clinical evidence status (stroke), code N Health, Superseded 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Person—clinical procedure timing, code N

Identifying and definitional attributes

Short name:	Clinical procedure timing (status)
METeOR identifier:	356827
Registration status:	Health, Standard 01/10/2008
Definition:	The timing of the provision of a clinical procedure, as represented by a code.
Data Element Concept:	Person—clinical procedure timing

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Procedure performed prior to this hospital presentation
2	Procedure performed during this hospital presentation

Data element attributes

Collection and usage attributes

Guide for use:	Record only for those procedure codes that apply.
Collection methods:	This data element should be recorded for each type of procedure performed that is pertinent to the treatment of acute coronary syndrome.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group

Relational attributes

Related metadata references:	See also Person—acute coronary syndrome procedure type, code NN Health, Standard 01/10/2008 Supersedes Person—clinical procedure timing, code N Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Person—coronary artery bypass graft date, DDMMYYYY

Identifying and definitional attributes

Short name:	Date of coronary artery bypass graft
Synonymous names:	CABG date
METeOR identifier:	344424
Registration status:	Health, Standard 01/10/2008
Definition:	The date on which a coronary artery bypass graft (CABG) procedure is performed on a person.
Data Element Concept:	Person—coronary artery bypass graft date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	Record the date of each CABG if more than one has been performed. CABG includes grafts and valve replacement, but does not include valve replacement alone.
Collection methods:	The date/s should be recorded from the medical record.

Relational attributes

Implementation in Data Set Specifications:	Coronary artery cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	Record when a coronary artery bypass graft is performed.

Person—coronary artery bypass graft location, code N

Identifying and definitional attributes

Short name:	Coronary artery bypass graft location
METeOR identifier:	347161
Registration status:	Health, Standard 01/10/2008
Definition:	The location of the artery where a coronary artery bypass graft has been performed, as represented by a code.
Data Element Concept:	Person—coronary artery bypass graft location

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Left anterior descending artery (LAD)
2	Diagonal artery
3	Left circumflex artery (LCx)
4	Inferior surface artery
5	Posterior descending artery
6	Right coronary artery
8	Other artery

Supplementary values:

Value	Meaning
9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

A bypass may be performed on more than one artery. In these cases more than one code may be recorded.

For each graft location the data elements Person-coronary artery stenosis location, code N; Person-maximum stenosis coronary artery, percentage N[NN] must also be recorded.

Relational attributes

Implementation in Data Set Specifications:

Coronary artery cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	Record when a coronary artery bypass graft is performed.
Information specific to this data set:	Codes provided for each location where a graft is performed during this hospital presentation.

Person—coronary artery stenosis location, code N

Identifying and definitional attributes

Short name:	Coronary artery stenosis location
METeOR identifier:	361087
Registration status:	Health, Standard 01/10/2008
Definition:	The coronary artery in which stenosis is located, as represented by a code.
Data Element Concept:	Person—coronary artery stenosis location

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Left anterior descending artery (LAD)
2	Diagonal artery
3	Left circumflex artery (LCx)
4	Left main coronary artery
5	Inferior surface artery
6	Posterior descending artery
7	Right coronary artery

Supplementary values:

Value	Meaning
9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	More than one code may be recorded. Record all codes that apply. For each coronary artery where stenosis is located the data element Person-maximum stenosis coronary artery, percentage N[NN] must also be recorded.
Collection methods:	This data is derived from visual reporting by the physician reporting the angiogram.

Relational attributes

Related metadata references:	See also Person—maximum stenosis coronary artery, percentage N[NN] Health, Standard 01/10/2008
Implementation in Data Set Specifications:	Coronary artery cluster Health, Standard 01/10/2008

Person—count of coronary artery lesions attempted, total number N[N]

Identifying and definitional attributes

Short name:	Number of coronary artery lesions attempted
METeOR identifier:	344404
Registration status:	Health, Standard 01/10/2008
Definition:	A count of number of a person's coronary artery lesions into which an attempt was made to pass a percutaneous coronary intervention (PCI) guidewire.
Data Element Concept:	Person—count of coronary artery lesions attempted

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	Record the total number of lesions into which an attempt was made to pass a PCI guidewire during a single given PCI procedure, whether they were successful or not. The number of lesions attempted should be reported for each PCI performed. The value '99' is not for use in primary data collections.
Collection methods:	The number of lesions attempted should be recorded from the angioplasty report.

Relational attributes

Implementation in Data Set Specifications:	Coronary artery cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	Record when a percutaneous coronary intervention is performed.

Person—count of coronary artery lesions successfully dilated, total number N[N]

Identifying and definitional attributes

Short name:	Number of coronary artery lesions successfully dilated
METeOR identifier:	344411
Registration status:	Health, Standard 01/10/2008
Definition:	The number of a person's coronary artery lesions successfully dilated.
Data Element Concept:	Person—count of coronary artery lesions successfully dilated

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

The number of lesions successfully dilated should be recorded for each percutaneous coronary intervention (PCI) performed.

Successful dilation is where:

- residual stenosis is less than 10% following coronary stenting; OR
- residual stenosis is less than 50% after balloon angioplasty alone.

The value '99' is not for use in primary data collections.

Collection methods:

The number of lesions successfully dilated should be recorded from the angioplasty report.

Relational attributes

Implementation in Data Set Specifications:

Coronary artery cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:

Record when a percutaneous coronary intervention is performed.

Person—count of coronary artery stents, total number N[N]

Identifying and definitional attributes

Short name:	Number of coronary artery stents
METeOR identifier:	344417
Registration status:	Health, Standard 01/10/2008
Definition:	The number of stents placed during a person's angioplasty procedure.
Data Element Concept:	Person—count of coronary artery stents

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	Number	
Format:	N[N]	
Supplementary values:	Value	Meaning
	99	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	The value '99' is not for use in primary data collections.
Collection methods:	Record the total number of coronary stents placed during the entire angioplasty procedure, regardless of the number of individual lesions.

Relational attributes

Implementation in Data Set Specifications:	Coronary artery cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	Record when a percutaneous coronary intervention with stent implantation (bare metal stent or drug eluting stent) is performed.

Person—country of birth, code (SACC 2008) NNNN

Identifying and definitional attributes

Short name:	Country of birth
METeOR identifier:	370943
Registration status:	Health, Standard 01/10/2008 Community services, Standard 02/06/2008
Definition:	The country in which the person was born, as represented by a code.
Data Element Concept:	Person—country of birth

Value domain attributes

Representational attributes

Classification scheme:	Standard Australian Classification of Countries 2008
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 2008 (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
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 ABS collection methods and is recommended for use whenever there is a requirement for comparison with ABS data (last viewed 2/6/2008).

Relational attributes

Related metadata references:

Supersedes Person—country of birth, code (SACC 1998) NNNN Health, Superseded 01/10/2008, Community services, Superseded 02/06/2008, Housing assistance, Standard 20/06/2005

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Commonwealth State/Territory Disability Agreement NMDS (July 2008) Community services, Standardisation pending 24/07/2008

Person—creatine kinase isoenzyme level (measured), total units per litre N[NNN]

Identifying and definitional attributes

Short name:	Creatine kinase level (U/L)
Synonymous names:	CK measured (U/L)
METeOR identifier:	349536
Registration status:	Health, Standard 01/10/2008
Definition:	A person's measured creatine kinase (CK) isoenzyme level in units per litre.
Data Element Concept:	Person—creatine kinase isoenzyme level

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
9998	Not measured
9999	Not stated/inadequately described

Proposed unit of measure: Units per litre (U/L)

Data element attributes

Collection and usage attributes

Guide for use:

CODE 8888 if test for CK was not done for this hospital presentation.

Where possible, several CK measures should be recorded and their associated date and time. At a minimum, an initial, peak and late value should be recorded.

When only one CK level is recorded, this should be the peak level.

Comments:

Elevation of CK isoenzyme is an indication of damage to muscle.

There are three different CK isoenzyme sub-forms:

- CK-MM (skeletal muscle)
- CK-MB (cardiac muscle)
- CK-BB (brain tissue)

Relational attributes

Related metadata references:

See also Laboratory standard—upper limit of normal range for creatine kinase isoenzyme, total units per litre N[NNN] Health, Standard 01/10/2008

See also Person—creatine kinase isoenzyme measured date, DDMMYYYY Health, Candidate 04/03/2008

See also Person—creatine kinase isoenzyme measured time,

	hhmm Health, Candidate 04/03/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Data set specification specific attributes

Information specific to this data set:	The measured CK isoenzyme levels and the timing of these measurements are important to the diagnosis of myocardial infarction.

Person—creatine kinase myocardial band isoenzyme measured date, DDMMYYYY

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Date creatine kinase MB isoenzyme (CK-MB) measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.71 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008 Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Data set specification specific attributes

Information specific to this data set:	The measured CK isoenzyme levels and the timing of these measurements are important to the diagnosis of myocardial infarction.

Person—creatine kinase myocardial band isoenzyme measured time, hhmm

Identifying and definitional attributes

Short name:	Time creatine kinase MB isoenzyme measured
METeOR identifier:	285179
Registration status:	Health, Standard 04/06/2004
Definition:	The time at which the person's creatine kinase myocardial band (CK-MB) isoenzyme was measured.
Data Element Concept:	Person—creatine kinase myocardial band isoenzyme measured time

Value domain attributes

Representational attributes

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

Source and reference attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	Record the time in 24-hour clock format.

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Time creatine kinase MB isoenzyme (CK-MB) measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.23 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008 Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Data set specification specific attributes

Information specific to this data set:	The measured CK isoenzyme levels and the timing of these measurements are important to the diagnosis of myocardial

infarction.

Person—creatine kinase-myocardial band isoenzyme level (measured), total micrograms per litre N[NNN]

Identifying and definitional attributes

Short name:	Creatine kinase MB isoenzyme level (micrograms per litre)
METeOR identifier:	356833
Registration status:	Health, Standard 01/10/2008
Definition:	A person's measured creatine kinase-myocardial band (CK-MB) isoenzyme level in micrograms per litre.
Data Element Concept:	Person—creatine kinase-myocardial band isoenzyme level

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
9998	Not measured
9999	Not stated/inadequately described

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

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:

CODE 9998 if test for CK-MB was not done for this hospital presentation.

Measured in different units dependent upon laboratory methodology.

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

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

Supersedes Person—creatine kinase-myocardial band isoenzyme level (measured), total micrograms per litre N[NNNN] Health, Superseded 01/10/2008

See also Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total micrograms per litre N[NNN] Health, Superseded 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Person—creatine kinase-myocardial band isoenzyme level (measured), total units per litre N[NNN]

Identifying and definitional attributes

Short name:	Creatine kinase MB isoenzyme level (units per litre)
Synonymous names:	Creatine kinase MB isoenzyme (CK-MB) - measured
METeOR identifier:	356830
Registration status:	Health, Standard 01/10/2008
Definition:	A person's measured creatine kinase-myocardial band (CK-MB) isoenzyme level in units per litre.
Data Element Concept:	Person—creatine kinase-myocardial band isoenzyme level

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
9998	Not measured
9999	Not stated/inadequately described

Proposed unit of measure: Units per litre (U/L)

Data element attributes

Collection and usage attributes

Guide for use:

CODE 9998 if test for CK-MB was not done for this hospital presentation.

Measured in different units dependent upon laboratory methodology.

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

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

Supersedes Person—creatine kinase-myocardial band isoenzyme level (measured), total international units N[NNN] Health, Superseded 01/10/2008

See also Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total units per litre N[NNN] Health, Standard 01/10/2008

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Data set specification specific attributes

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

Person—creatinine serum level measured date, DDMMYYYY

Identifying and definitional attributes

Short name:	Date creatinine serum level measured
METeOR identifier:	343843
Registration status:	Health, Standard 01/10/2008
Definition:	The date when the person's creatinine serum level was measured.
Data Element Concept:	Person—creatinine serum level measured date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Collection methods:	Record the date of the most recent creatinine serum level measurement taken in the last 12 months. Date to be recorded from documentation on the laboratory test results and/or the medical record.

Relational attributes

Related metadata references:	See also Person—creatinine serum level, micromoles per litre NN[NN] Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Data set specification specific attributes

Information specific to this data set:	In settings where the monitoring of a person's health is ongoing and where a measure can change over time (such as general practice), the Service contact—service contact date, DDMMYYYY should be recorded. Record absolute result of the most recent serum creatinine measurement in the last 12 months to the nearest µmol/L (micromoles per litre).

Person—creatinine serum level, total micromoles per litre NN[NN]

Identifying and definitional attributes

Short name:	Creatinine serum level (measured)
METeOR identifier:	360936
Registration status:	Health, Standard 01/10/2008
Definition:	A person's serum creatinine level measured in micromoles per litre.
Data Element Concept:	Person—creatinine serum level

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	There is no agreed standard as to which units serum creatinine should be recorded in. Note: If the measurement is obtained in mmol/L it is to be multiplied by 1000.
Collection methods:	Measurement of creatinine should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority. • Single venous blood test taken at the time of other screening blood tests. • Fasting not required.
Comments:	Serum creatinine can be used to help determine renal function. Serum creatinine by itself is an insensitive measure of renal function because it does not increase until more than 50% of renal function has been lost. Serum creatinine together with a patient's age, weight and sex can be used to calculate glomerular filtration rate (GFR), which is an indicator of renal status/ function. The calculation uses the Cockcroft-Gault formula. Creatinine is normally produced in fairly constant amounts in the muscles, as a result the breakdown of phosphocreatine. It passes into the blood and is excreted in the urine. Serum creatinine can be used to help determine renal function. The elevation in the creatinine level in the blood indicates disturbance in kidney function. GFR decreases with age, but serum creatinine remains relatively stable. When serum creatinine is measured, renal

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

GFR (ml/min) = $\frac{(140 - \text{age [yrs]}) \times \text{body wt (kg)}}{814 \times \text{serum creatinine (mmol/l)}}$ [x 0.85 (for women)]

An alternative formula is derived from the Modification of Diet in Renal Disease (MDRD) study and does not rely on knowledge of body weight:

GFR (ml/min/1.73m2) = 32788 x creatinine$^{-1.154}$ (umol/L) x age$^{-0.203}$ x (males: 1, females: 0.742).

To determine the degree of chronic renal impairment

GFR > 90ml/min - normal

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

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

GFR 0 - 30 ml/min - severe renal impairment

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

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

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

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

Source and reference attributes

Submitting organisation:	Cardiovascular Data Working Group National Diabetes Data Working Group
Origin:	Caring for Australians with Renal Impairment (CARI) Guidelines. Australian Kidney Foundation

Relational attributes

Related metadata references:	Supersedes Person—creatinine serum level, micromoles per litre NN[NN] Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Person—date of birth, DDMMYYYY

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

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

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

Comments:

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

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

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

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

Source and reference attributes

Origin:

National Health Data Committee

National Community Services Data Committee

Reference documents:

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

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

Relational attributes

Related metadata references:

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

See also Date—estimate indicator, code N Community services, Standard 27/04/2007

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

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

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

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

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

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

Health, Superseded 04/07/2007

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

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008

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

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Child protection and support services (CPSS) client cluster

Community services, Standard 30/04/2008

Child protection and support services (CPSS) sibling cluster Community services, Standard 30/04/2008

Children's Services NMDS Community services, Standard 18/12/2007

Commonwealth State/Territory Disability Agreement NMDS (July 2008) Community services, Standardisation pending 24/07/2008

Commonwealth State/Territory Disability Agreement NMDS - 1 July 2006 Community services, Standard 27/04/2007

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

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

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

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

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

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

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

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

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

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

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

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

Juvenile Justice NMDS Community services, Standard 27/03/2007

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

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

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

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

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

Perinatal NMDS Health, Superseded 06/09/2006

Perinatal NMDS Health, Superseded 07/12/2005

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

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

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

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

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

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

SAAP Client Collection National Minimum Data Set Community services, Standard 30/11/2007

Person—date of death, DDMMYYYY

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Date of death, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.54 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

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

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

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

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

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

Data set specification specific attributes

Information specific to this data set:

If a date of death is recorded, the cause of death must also be recorded. These data are recorded regardless of the cause of death.

Person—diabetes mellitus status, code NN

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

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

Supplementary values:

99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

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

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

CODE 01 Type 1 diabetes

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

CODE 02 Type 2 diabetes

Type 2 includes the common major form of diabetes, which

results from defect(s) in insulin secretion, almost always with a major contribution from insulin resistance.

CODE 03 Gestational diabetes mellitus (GDM)

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

CODE 04 Other (secondary diabetes)

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

CODE 05 Previous GDM

Where the person has a history of GDM.

CODE 06 Impaired fasting glycaemia (IFG)

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

CODE 07 Impaired glucose tolerance (IGT)

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

CODE 08 Not diagnosed with diabetes

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

CODE 09 Not assessed

The subject has not had their diabetes status assessed.

CODE 99 Not stated/inadequately described

This code is for unknown or information unavailable.

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

Source and reference attributes

Origin: Developed based on Definition, Diagnosis and Classification of Diabetes Mellitus and its Complications Part 1: Diagnosis and Classifications of Diabetes Mellitus Provisional Report of a World Health Organization Consultation (Alberti & Zimmet

1998).

Data element attributes

Collection and usage attributes

Collection methods:

Diabetes (clinical):

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

Source and reference attributes

Submitting organisation:

Cardiovascular Data Working Group

National Diabetes Data Working Group

Relational attributes

Related metadata references:

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

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008

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

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

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

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

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

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

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

Person—diabetes therapy type, code NN

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

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

Supplementary values:

99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 01 Diet & exercise only

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

CODE 98 Nil - not currently receiving diabetes treatment

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

CODE 99 Not stated/inadequately described

Use this code when missing information.

Data element attributes

Collection and usage attributes

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

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

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

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Cardiovascular Data Working Group

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

Relational attributes

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

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

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

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

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

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

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

Person—diagnostic cardiac catheterisation date, DDMMYYYY

Identifying and definitional attributes

Short name:	Date of diagnostic cardiac catheterisation
Synonymous names:	Date of coronary angiography
METeOR identifier:	359791
Registration status:	Health, Standard 01/10/2008
Definition:	The date when cardiac catheterisation is performed for diagnostic purposes.
Data Element Concept:	Person—diagnostic cardiac catheterisation date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item includes coronary angiography which is performed using a catheter.

Source and reference attributes

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

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Person—diagnostic cardiac catheterisation time, hhmm

Identifying and definitional attributes

Short name:	Time of diagnostic cardiac catheterisation
Synonymous names:	Time of coronary angiography
METeOR identifier:	359777
Registration status:	Health, Standard 01/10/2008
Definition:	The time when cardiac catheterisation is performed for diagnostic purposes.
Data Element Concept:	Person—diagnostic cardiac catheterisation time

Value domain attributes

Representational attributes

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

Source and reference attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item includes coronary angiography which is performed using a catheter.

Source and reference attributes

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

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Person—dyslipidaemia treatment with anti-lipid medication indicator (current), code N

Identifying and definitional attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 9 Not stated/inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes: Record if a person is being treated for dyslipidaemia using anti-lipid medication.

CODE 2 No: Record if a person is not being treated for dyslipidaemia using anti-lipid medication.

Collection methods:

Ask the individual if he/she is currently treated with anti-lipid medication. Alternatively obtain the relevant information from appropriate documentation.

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Person—dyslipidaemia treatment status (anti-lipid medication), code N Health, Superseded 21/09/2005
Implementation in Data Set	Acute coronary syndrome (clinical) DSS Health, Standard

Specifications:	01/10/2008 Diabetes (clinical) DSS Health, Standard 21/09/2005

Person—electrocardiogram Q waves indicator, yes/no code N

Identifying and definitional attributes

Short name:	ECG - Q waves indicator
METeOR identifier:	347711
Registration status:	Health, Standard 01/10/2008
Definition:	An indicator of whether Q waves are present on a person's follow-up electrocardiogram (ECG), as represented by a code.
Data Element Concept:	Person— electrocardiogram Q waves indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 9 Not stated/inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:

Code 1 Yes

Record if Q waves are identified on the follow-up electrocardiogram.

Code 2 No

Record if no Q waves are identified on the follow-up electrocardiogram.

Collection methods:

Do not record the presence of Q waves for the initial ECG. This data element should only be collected for follow-up ECGs.

Relational attributes

Related metadata references:	See also Electrocardiogram—new Q waves indicator, yes/no code N Health, Standard 01/10/2008
Implementation in Data Set Specifications:	Electrocardiogram cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	Record for all follow up electrocardiograms performed after the

initial electrocardiogram.

Person—fibrinolytic drug administered, code N

Identifying and definitional attributes

Short name:	Fibrinolytic drug used
METeOR identifier:	356870
Registration status:	Health, Standard 01/10/2008
Definition:	The type of fibrinolytic drug administered to a person, as represented by a code.
Data Element Concept:	Person—fibrinolytic drug administered

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Streptokinase
	2	t-PA (Tissue Plasminogen Activator) (Alteplase)
	3	r-PA (Reteplase)
	4	TNK t-PA (Tenecteplase)
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group

Relational attributes

Related metadata references:	Supersedes Person—fibrinolytic drug administered, code N Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	If prescribed, provide the fibrinolytic drug administered.

Person—functional stress test performed indicator, yes/no code N

Identifying and definitional attributes

Short name:	Functional stress test performed indicator
METeOR identifier:	347697
Registration status:	Health, Standard 01/10/2008
Definition:	An indicator of whether a functional stress test was performed on a person, as represented by a code.
Data Element Concept:	Person—functional stress test performed indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

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

Data element attributes

Collection and usage attributes

Guide for use:

Code 1 Yes
Record if a functional stress test was performed .
Code 2 No
Record if no functional stress test was performed.

Relational attributes

Implementation in Data Set Specifications:

Functional stress test cluster Health, Standard 01/10/2008

Person—glycosylated haemoglobin level (measured), percentage N[N].N

Identifying and definitional attributes

Short name:	Glycosylated haemoglobin level (measured)
METeOR identifier:	270325
Registration status:	Health, Standard 01/03/2005
Definition:	A person's glycosylated haemoglobin (HbA1c) level, measured as percentage.
Data Element Concept:	Person—glycosylated haemoglobin level

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
99.9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

HbA1c results vary between laboratories; use the same laboratory for repeated testing.

When reporting, record absolute result of the most recent HbA1c level in the last 12 months.

Record the absolute result of the test (%).

Collection methods:

Test is performed in accredited laboratories:

- A single blood sample is sufficient and no preparation of the patient is required.
- Measure HbA1c ideally using High Performance Liquid Chromatography (HPLC).

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.
Reference documents:	Koening, R. J. Peterson, CM and Kilo, C et al. Hemoglobin A1c as an indicator of the degree of glucose intolerance in diabetes. Diabetes 259 (1976): 230-232. Nathan, D.M., Singer, D.E, Hurxthal, K, and Goodson, J.D. The clinical information value of the glycosylated hemoglobin assay. N. Eng. J. Med. 310 (1984): 341-346.

Relational attributes

Related metadata references:

See also Laboratory standard—upper limit of normal range of glycosylated haemoglobin, percentage N[N].N Health,

	Standard 01/03/2005 Supersedes Glycosylated Haemoglobin (HbA1c) - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18 KB)
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008 Diabetes (clinical) DSS Health, Superseded 21/09/2005 Diabetes (clinical) DSS Health, Standard 21/09/2005

Person—height (measured), total centimetres NN[N].N

Identifying and definitional attributes

Short name:	Height (measured)
METeOR identifier:	270361
Registration status:	Health, Standard 01/03/2005
Definition:	The height of a person measured in centimetres.
Context:	Public health and health care
Data Element Concept:	Person—height

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NN[N].N
Maximum character length:	4
Supplementary values:	Value: 999.9 — Meaning: Not measured
Unit of measure:	Centimetre (cm)

Data element attributes

Collection and usage attributes

Guide for use:

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

Measurements of height should be assessed in relation to children and adolescents' age and pubertal status.

Collection methods:

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

Measurement protocol:

Height measurements can be based on recumbent length or standing height. In general, length measurements are recommended for children under 2 years of age and height measurements for others.

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

The graduations on the metric rule should be at 0.1 cm intervals, and the metric rule should have the capacity to measure up to at least 210 cm.

Measurement intervals and labels should be clearly readable under all conditions of use of the instrument.

Apparatus that allows height to be measured while the subject

stands on a platform scale is not recommended.

Adults and children who can stand:

The subject should be measured without shoes (i.e. is barefoot or wears thin socks) and wears little clothing so that the positioning of the body can be seen. Anything that may affect or interfere with the measurement should be noted on the data collection form (e.g. hairstyles and accessories, or physical problems). The subject stands with weight distributed evenly on both feet, heels together, and the head positioned so that the line of vision is at right angles to the body. The correct position for the head is in the Frankfort horizontal plan (Norton et al. 1996). The arms hang freely by the sides. The head, back, buttocks and heels are positioned vertically so that the buttocks and the heels are in contact with the vertical board. To obtain a consistent measure, the subject is asked to inhale deeply and stretch to their fullest height. The measurer applies gentle upward pressure through the mastoid processes to maintain a fully erect position when the measurement is taken. Ensure that the head remains positioned so that the line of vision is at right angles to the body, and the heels remain in contact with the base board.

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

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

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

Infants:

For the measurement of supine length of children up to and including 2 years of age, two observers are required. One observer positions the head correctly while the other ensures the remaining position is correct and brings the measuring board in contact with the feet. The subject lies in a supine position on a recumbent length table or measuring board. The crown of the head must touch the stationary, vertical headboard. The subject's head is held with the line of vision aligned perpendicular to the plane of the measuring surface. The shoulders and buttocks must be flat against the table top, with the shoulders and hips aligned at right angles to the long axis of the body. The legs must be extended at the hips and knees and lie flat against the table top and the arms rest against the sides of the trunk. The measurer must ensure that the legs remain flat on the table and must shift the movable board

against the heels. In infants care has to be taken to extend the legs gently. In some older children two observers may also be required.

In general, length or height is measured and reported to the nearest 0.1 cm. For any child, the length measurement is approximately 0.5 - 1.5 cm greater than the height measurement. It is therefore recommended that when a length measurement is applied to a height-based reference for children over 24 months of age (or over 85 cm if age is not known), 1.0 cm be subtracted before the length measurement is compared with the reference. It is also recommended that as a matter of procedure and data recording accuracy, the date be recorded when the change is made from supine to standing height measure.

Validation and quality control measures:

All equipment, whether fixed or portable should be checked prior to each measurement session to ensure that both the headboard and floor (or footboard) are at 90 degrees to the vertical rule. With some types of portable anthropometer it is necessary to check the correct alignment of the headboard, during each measurement, by means of a spirit level. Within- and, if relevant, between-observer variability should be reported. They can be assessed by the same (within-) or different (between-) observers repeating the measurement of height, on the same subjects, under standard conditions after a short time interval. The standard deviation of replicate measurements (technical error of measurement (Pederson & Gore 1996)) between observers should not exceed 5 mm and be less than 5 mm within observers.

Extreme values at the lower and upper end of the distribution of measured height should be checked both during data collection and after data entry. Individuals should not be excluded on the basis of true biological difference. Last digit preference, and preference or avoidance of certain values, should be analysed in the total sample and (if relevant) by observer, survey site and over time if the survey period is long.

Comments:

This metadata item applies to persons of all ages. It is recommended for use in population surveys and health care settings.

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

Metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. However 5-year age groups are not generally suitable for children and adolescents. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current

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

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

Height

70 cm = Height

75 cm = Height

... in 5 cm categories

185 cm = Height

Height => 190 cm

Relational attributes

Related metadata references:

Supersedes Height - measured, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (28.74 KB)

Is used in the formation of Adult—body mass index (measured), ratio NN[N].N[N] Health, Standard 01/03/2005

Is used in the formation of Child—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005

Is used in the formation of Child—body mass index (measured), ratio NN[N].N[N] Health, Standard 01/03/2005

Is used in the formation of Adult—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

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

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

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

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

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

Person—high-density lipoprotein cholesterol level (measured), total millimoles per litre [N].NN

Identifying and definitional attributes

Short name:	Cholesterol—HDL (measured)
METeOR identifier:	270401
Registration status:	Health, Standard 01/03/2005
Definition:	A person's high-density lipoprotein cholesterol (HDL-C), measured in mmol/L.
Data Element Concept:	Person—high-density lipoprotein cholesterol level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	[N].NN
Maximum character length:	3
Supplementary values:	Value: 9.99 — Meaning: Not measured/inadequately described
Unit of measure:	Millimole per litre (mmol/L)

Data element attributes

Collection and usage attributes

Guide for use:	When reporting, record whether or not the measurement of High-density Lipoprotein Cholesterol (HDL-C) was performed in a fasting specimen. In settings where the monitoring of a person's health is ongoing and where a measure can change over time (such as general practice), the date of assessment should be recorded.
Collection methods:	When reporting, record absolute result of the most recent HDL-Cholesterol measurement in the last 12 months to the nearest 0.01 mmol/L. Measurement of lipid levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authorities. • To be collected as a single venous blood sample, preferably following a 12-hour fast where only water and medications have been consumed. • Prolonged tourniquet use can artefactually increase levels by up to 20%.

Source and reference attributes

Submitting organisation:	Cardiovascular Data Working Group National Diabetes Data Working Group
Origin:	National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand, Lipid Management Guidelines -

2001, MJA 2001; 175: S57-S88.

Relational attributes

Related metadata references:

Supersedes Cholesterol-HDL - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.97 KB)

Is used in the formation of Person—low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N Health, Standard 01/10/2008

Is used in the formation of Person—low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N Health, Superseded 01/10/2008

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008

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

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

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

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

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

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

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

Person—hypertension treatment with antihypertensive medication indicator (current), code N

Identifying and definitional attributes

Short name:	Hypertension - treatment
METeOR identifier:	302442
Registration status:	Health, Standard 21/09/2005
Definition:	Whether a person is currently being treated for hypertension (high blood pressure) using antihypertensive medication, as represented by a code.
Data Element Concept:	Person—hypertension treatment with antihypertensive medication indicator

Value domain attributes

Representational attributes

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

Collection and usage attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.
Reference documents:	Pahor M, Psaty BM, Furberg CD. Treatment of hypertensive patients with diabetes. Lancet 1998; 351:689-90. Tight blood

pressure control and risk of macrovascular and microvascular complications in type 2 diabetes: UKPDS 38. UK Prospective Diabetes Study Group [erratum appears in Br Med J 1999; 318:29]. Br Med J 1998; 317:703-13.

Grossman E, Messerli FH, Goldbourt U, Curb JD, Pressel SL, Cutler JA, Savage PJ, Applegate WB, Black H, et al. Effect of diuretic-based antihypertensive treatment on cardiovascular disease risk in older diabetic patients with isolated systolic hypertension. Systolic Hypertension in the Elderly Program Cooperative Research Group. JAMA 1996; 276:1886-92.

Hypertension in diabetes[Australian Prescriber Feb 2002]. American Journal of Preventive Medicine 2002;21.

Relational attributes

Related metadata references:	Supersedes Person—hypertension treatment status (antihypertensive medication), code N Health, Superseded 21/09/2005
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008 Diabetes (clinical) DSS Health, Standard 21/09/2005

Person—implantable cardiac defibrillator procedure date, DDMMYYYY

Identifying and definitional attributes

Short name:	Date of implantable cardiac defibrillator procedure
Synonymous names:	ICD procedure date
METeOR identifier:	359611
Registration status:	Health, Standard 01/10/2008
Definition:	The date when a procedure is performed for insertion of an implantable cardiac defibrillator (ICD).
Data Element Concept:	Person—implantable cardiac defibrillator procedure 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

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

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Person—implantable cardiac defibrillator procedure time, hhmm

Identifying and definitional attributes

Short name:	Time of implantable cardiac defibrillator procedure
Synonymous names:	ICD procedure time
METeOR identifier:	359678
Registration status:	Health, Standard 01/10/2008
Definition:	The time when a procedure is performed for insertion of an implantable cardiac defibrillator (ICD).
Data Element Concept:	Person—implantable cardiac defibrillator procedure time

Value domain attributes

Representational attributes

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

Source and reference attributes

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

Data element attributes

Source and reference attributes

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

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Person—Indigenous status, code N

Identifying and definitional attributes

Short name:	Indigenous status
METeOR identifier:	291036
Registration status:	Health, Standard 04/05/2005 Community services, 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:	Person—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 Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008

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

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

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

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

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

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

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

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

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

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

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

Admitted patient palliative care NMDS 2006-2007 Health,

Superseded 23/10/2006

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

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

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

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

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

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

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

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

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

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

Child protection and support services (CPSS) - out-of-home care NMDS (July 2007) Community services, Superseded 01/05/2008

Child protection and support services (CPSS) - out-of-home care NMDS pilot (2008) Community services, Standard 30/04/2008

Child protection and support services (CPSS) client cluster Community services, Standard 30/04/2008

Children's Services NMDS Community services, Standard 18/12/2007

Commonwealth State/Territory Disability Agreement NMDS (July 2008) Community services, Standardisation pending 24/07/2008

Commonwealth State/Territory Disability Agreement NMDS - 1 July 2006 Community services, Standard 27/04/2007

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

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

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

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

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

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

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

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

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

Juvenile Justice NMDS Community services, Standard 27/03/2007

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

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

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

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

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

Perinatal NMDS Health, Superseded 06/09/2006

Perinatal NMDS Health, Superseded 07/12/2005

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

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

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

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

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

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

SAAP Client Collection National Minimum Data Set Community services, Standard 30/11/2007

SAAP Demand for Accommodation National Minimum Data Set Community services, Standard 30/11/2007

Person—intra-aortic balloon pump procedure date, DDMMYYYY

Identifying and definitional attributes

Short name:	Date of intra-aortic balloon pump procedure
METeOR identifier:	359623
Registration status:	Health, Standard 01/10/2008
Definition:	The date when a procedure is performed for insertion of an intra-aortic balloon pump.
Data Element Concept:	Person—intra-aortic balloon pump procedure 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

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

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Person—intra-aortic balloon pump procedure time, hhmm

Identifying and definitional attributes

Short name:	Time of intra-aortic balloon pump procedure
METeOR identifier:	359691
Registration status:	Health, Standard 01/10/2008
Definition:	The time when a procedure is performed for insertion of an intra-aortic balloon pump.
Data Element Concept:	Person—intra-aortic balloon pump procedure time

Value domain attributes

Representational attributes

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

Source and reference attributes

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

Data element attributes

Source and reference attributes

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

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Person—intravenous fibrinolytic therapy date, DDMMYYYY

Identifying and definitional attributes

Short name:	Date of intravenous fibrinolytic therapy
METeOR identifier:	356921
Registration status:	Health, Standard 01/10/2008
Definition:	The date intravenous (IV) fibrinolytic therapy was first administered or initiated.
Data Element Concept:	Person—intravenous fibrinolytic therapy date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group

Relational attributes

Related metadata references:	Supersedes Person—intravenous fibrinolytic therapy date, DDMMYYYY Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	If prescribed, provide the date when the fibrinolytic therapy is administered.

Person—intravenous fibrinolytic therapy time, hhmm

Identifying and definitional attributes

Short name:	Time of intravenous fibrinolytic therapy
METeOR identifier:	360949
Registration status:	Health, Standard 01/10/2008
Definition:	The time intravenous (IV) fibrinolytic therapy was first administered to a person.
Data Element Concept:	Person—intravenous fibrinolytic therapy time

Value domain attributes

Representational attributes

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

Source and reference attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	If initiated by a bolus dose whether in a pre-hospital setting, emergency department or inpatient unit/ward, the time the initial bolus was administered should be recorded.
Comments:	This is used to calculate the time between initial presentation and reperfusion.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group

Relational attributes

Related metadata references:	Supersedes Person—intravenous fibrinolytic therapy time, hhmm Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	If prescribed, provide the time when the fibrinolytic therapy is administered.

Person—Killip classification, code N

Identifying and definitional attributes

Short name:	Killip classification code
METeOR identifier:	285151
Registration status:	Health, Standard 04/06/2004
Definition:	The Killip class, as a measure of haemodynamic compromise, of the person at the time of presentation, as represented by a code.
Data Element Concept:	Person—Killip classification

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Class 1
2	Class 2
3	Class 3
4	Class 4

Supplementary values:

Value	Meaning
8	Other
9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Rales or crepitations represent evidence of pulmonary interstitial oedema on lung auscultation and an S_3 is an audible extra heart sound by cardiac auscultation.

CODE 1 Class 1

Absence of crepitations/rales over the lung fields and absence of S_3.

CODE 2 Class 2

Crepitations/rales over 50% or less of the lung fields or the presence of an S_3.

CODE 3 Class 3

Crepitations/rales over more than 50% of the lung fields.

CODE 4 Class 4

Cardiogenic Shock. Clinical criteria for cardiogenic shock are hypotension (a systolic blood pressure of less than 90 mmHg for at least 30 minutes or the need for supportive measures to maintain a systolic blood pressure of greater than or equal to 90 mmHg), end-organ hypoperfusion (cool extremities or a urine output of less than 30 ml/h, and a heart rate of greater than or equal to 60 beats per minute). The haemodynamic criteria are a cardiac index of no more than 2.2 l/min per square meter of body-surface area and a pulmonary-capillary wedge pressure of at least 15 mmHg.

Data element attributes

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

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

Relational attributes

Related metadata references: Supersedes Killip classification code, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.68 KB)

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008

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

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Data set specification specific attributes

Information specific to this data set: For Acute Coronary Syndrome (ACS) reporting, this data element describes the objective evidence of haemodynamic compromise by clinical examination at the time of presentation. Rales or crepitations represent evidence of pulmonary interstitial oedema on lung auscultation and an S3 is an audible extra heart sound by cardiac auscultation.

Person—low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N

Identifying and definitional attributes

Short name:	Cholesterol—LDL (calculated)
METeOR identifier:	359262
Registration status:	Health, Standard 01/10/2008
Definition:	A person's calculated low-density lipoprotein cholesterol (LDL-C) in millimoles per litre.
Data Element Concept:	Person—low-density lipoprotein cholesterol level

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
99.9	Not stated/inadequately described

Unit of measure: Millimole per litre (mmol/L)

Data element attributes

Collection and usage attributes

Guide for use:

Formula:

LDL-C = (plasma total cholesterol) - (high density lipoprotein cholesterol) - (fasting plasma triglyceride divided by 2.2).

Collection methods:

The LDL-C is usually calculated from the Friedwald Equation (Friedwald et al. 1972), which depends on knowing the blood levels of the total cholesterol and HDL-C and the fasting level of the triglyceride.

Note that the Friedwald equation becomes unreliable when the plasma triglyceride exceeds 4.5 mmol/L.

Note also that while cholesterol levels are reliable for the first 24 hours after the onset of acute coronary syndromes, they may be unreliable for the subsequent 8 weeks after an event.

- Measurement of lipid levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authorities.
- To be collected as a single venous blood sample, preferably following a 12-hour fast where only water and medications have been consumed.

Comments:

High blood cholesterol is a key factor in heart, stroke and vascular disease, especially coronary heart disease (CHD).

Poor nutrition can be a contributing factor to heart, stroke and vascular disease as a population's level of saturated fat intake is the prime determinant of its level of blood cholesterol.

The majority of the cholesterol in plasma is transported as a component of LDL-C. Recent trials support a target LDL-C of <2.0 mmol/L for high risk patients with existing coronary heart disease.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Origin: National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand, Lipid Management Guidelines - 2001, MJA 2001; 175: S57-S88.

National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand, Position Statement on Lipid Management - 2005, Heart, Lung and Circulation 2005; 14: 275-291.

Relational attributes

Related metadata references: Supersedes Person—low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N Health, Superseded 01/10/2008

Is formed using Person—cholesterol level (measured), total millimoles per litre N[N].N Health, Superseded 01/10/2008

Is formed using Person—high-density lipoprotein cholesterol level (measured), total millimoles per litre [N].NN Health, Standard 01/03/2005

Is formed using Person—triglyceride level (measured), total millimoles per litre N[N].N Health, Superseded 01/10/2008

Is formed using Health service event—fasting indicator, code N Health, Standard 21/09/2005

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Person—maximum stenosis coronary artery, percentage N[NN]

Identifying and definitional attributes

Short name:	Maximum stenosis coronary artery
METeOR identifier:	344335
Registration status:	Health, Standard 01/10/2008
Definition:	The percentage of stenosis at it's maximal point in a person's coronary artery.
Data Element Concept:	Person—maximum stenosis coronary artery

Value domain attributes

Representational attributes

Representation class:	Percentage
Data type:	Number
Format:	N[NN]
Maximum character length:	3

Supplementary values:

Value	Meaning
999	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	Stenosis represents the percentage of occlusion, from 0 to 100%, associated with the identified vessel system. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the 'normal' vessel proximal and distal to the lesion. In instances where multiple lesions are present in a coronary artery, record the highest percentage stenosis noted.
Collection methods:	This data is derived from visual recording by the physician reporting the angiogram.

Relational attributes

Related metadata references:	See also Person—coronary artery stenosis location, code N Health, Standard 01/10/2008
Implementation in Data Set Specifications:	Coronary artery cluster Health, Standard 01/10/2008

Person—most recent stroke date, DDMMYYYY

Identifying and definitional attributes

Short name:	Date of most recent stroke
Synonymous names:	CVA date
METeOR identifier:	338263
Registration status:	Health, Standard 01/10/2008
Definition:	The date of the most recent cerebrovascular accident or stroke experienced by a person.
Data Element Concept:	Person—most recent stroke date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Collection methods:	The date should be self-reported by the person or recorded by the clinician based on the notes in the medical record. The occurrence of a stroke should be evidenced by a record of cerebral imaging (CT or MRI).

Relational attributes

Related metadata references:	See also Person—clinical evidence status (stroke), code N Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Data set specification specific attributes

Information specific to this data set:	Record the date of the most recent stroke that preceded presentation to the hospital.

Person—non-invasive ventilation administration date, DDMMYYYY

Identifying and definitional attributes

Short name:	Date of non-invasive ventilation administration
METeOR identifier:	359637
Registration status:	Health, Standard 01/10/2008
Definition:	The date when non-invasive ventilation is administered.
Data Element Concept:	Person—non-invasive ventilation administration 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

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

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Person—non-invasive ventilation administration time, hhmm

Identifying and definitional attributes

Short name:	Time of non-invasive ventilation administration
METeOR identifier:	359647
Registration status:	Health, Standard 01/10/2008
Definition:	The time of administration of non-invasive ventilation.
Data Element Concept:	Person—non-invasive ventilation administration time

Value domain attributes

Representational attributes

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

Source and reference attributes

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

Data element attributes

Source and reference attributes

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

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Person—pacemaker insertion date, DDMMYYYY

Identifying and definitional attributes

Short name:	Date of pacemaker insertion
METeOR identifier:	359591
Registration status:	Health, Standard 01/10/2008
Definition:	The date when a procedure is performed for insertion of a pacemaker.
Data Element Concept:	Person—pacemaker insertion 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

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

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Person—pacemaker insertion time, hhmm

Identifying and definitional attributes

Short name:	Time of pacemaker insertion
METeOR identifier:	359662
Registration status:	Health, Standard 01/10/2008
Definition:	The time when a procedure is performed for insertion of a pacemaker.
Data Element Concept:	Person—pacemaker insertion time

Value domain attributes

Representational attributes

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

Source and reference attributes

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

Data element attributes

Source and reference attributes

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

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Person—percutaneous coronary intervention procedure type, code N

Identifying and definitional attributes

Short name:	Percutaneous coronary intervention procedure type
Synonymous names:	PCI procedure type
METeOR identifier:	359751
Registration status:	Health, Standard 01/10/2008
Definition:	The type of procedure performed during a percutaneous coronary intervention (PCI), as represented by a code.
Data Element Concept:	Person—percutaneous coronary intervention procedure type

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	String	
Format:	N	
Permissible values:	Value	Meaning
	1	Balloon angioplasty only
	2	Bare metal stent implantation
	3	Drug-eluting stent implantation
Supplementary values:	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Balloon angioplasty only

Use this code where only balloon angioplasty has been performed during a percutaneous coronary intervention.

CODE 2 Bare metal stent implantation

Use this code where a bare metal stent has been implanted during a percutaneous coronary intervention.

CODE 3 Drug-eluting stent implantation

Use this code where at least one drug-eluting stent has been implanted during a percutaneous coronary intervention (i.e. if more than one stent has been placed during the procdure and at least one stent is a drug-eluting stent).

CODES 2 and 3 include the performance of balloon angioplasty.

Data element attributes

Source and reference attributes

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

Relational attributes

Implementation in Data Set Specifications:	Coronary artery cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	Record when a percutaneous coronary intervention is performed. This includes those performed for primary, rescue or revascularisation reasons.

Person—person identifier, XXXXXX[X(14)]

Identifying and definitional attributes

Short name:	Person identifier
METeOR identifier:	290046
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005
Definition:	Person identifier unique within an establishment or agency.
Data Element Concept:	Person—person identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	XXXXXX[X(14)]
Maximum character length:	20

Data element attributes

Collection and usage attributes

Guide for use:	Individual agencies, establishments or collection authorities may use their own alphabetic, numeric or alphanumeric coding systems. Field cannot be blank.

Source and reference attributes

Reference documents:	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references:	Supersedes Person—person identifier (within establishment/agency), XXXXXX[X(14)] Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008 Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008 Admitted patient care NMDS Health, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008 Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Juvenile Justice NMDS Community services, Standard 27/03/2007

Non-admitted patient emergency department care NMDS

Health, Superseded 07/12/2005

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

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

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

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

Perinatal NMDS Health, Superseded 06/09/2006

Perinatal NMDS Health, Superseded 07/12/2005

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

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

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

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

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

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

Person—premature cardiovascular disease family history status, code N

Identifying and definitional attributes

Short name:	Premature cardiovascular disease family history (status)
METeOR identifier:	359398
Registration status:	Health, Standard 01/10/2008
Definition:	Whether a person has a first degree relative (father, mother or sibling) who has had a vascular event or condition diagnosed before the age of 60 years, as represented by a code.
Data Element Concept:	Person—premature cardiovascular disease family history status

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
	3	Family history status not known
Supplementary values:	9	Not recorded

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1: Yes, the person has a first-degree relative under the age of 60 years who has had a vascular disease/condition diagnosed.

CODE 2: No, the person does not have a first-degree relative under the age of 60 years who has had a vascular disease/condition diagnosed.

CODE 3: Family history status not known, the existence of a premature family history for cardiovascular disease cannot be determined.

CODE 9: Not recorded, the information as to the existence of a premature family history for cardiovascular disease has not been recorded.

Source and reference attributes

Submitting organisation:	Cardiovascular Data Working Group
Origin:	Guidelines Subcommittee of the World Health Organization/International Society of Hypertension (WHO-ISH): 1999 WHO-ISH guidelines for management of hypertension. J Hypertension 1999; 17: 151 - 83.

Relational attributes

Related metadata references:	Supersedes Person—premature cardiovascular disease family history status, code N Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Person—primary percutaneous coronary intervention date, DDMMYYYY

Identifying and definitional attributes

Short name:	Date of primary percutaneous coronary intervention
Synonymous names:	Primary PCI date
METeOR identifier:	359175
Registration status:	Health, Standard 01/10/2008
Definition:	Date of the primary percuatenous coronary intervention (PCI).
Data Element Concept:	Person—primary percutaneous coronary intervention date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	Primary PCI relates to the first balloon angioplasty inflation and/or stent implantation for reperfusion therapy of a ST-segment-elevation myocardial infarction (STEMI). The date or the first balloon angioplasty inflation should be recorded, even if this includes implantation of a stent.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group

Relational attributes

Related metadata references:	Supersedes Person—first angioplasty balloon inflation or stenting date, DDMMYYYY Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Coronary artery cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	Record when a primary percutaneous coronary intervention is performed.

Person—primary percutaneous coronary intervention time, hhmm

Identifying and definitional attributes

Short name:	Time of primary percutaneous coronary intervention
Synonymous names:	Primary PCI time
METeOR identifier:	359201
Registration status:	Health, Standard 01/10/2008
Definition:	The time of the primary percutaneous coronary intervention (PCI).
Data Element Concept:	Person—primary percutaneous coronary intervention time

Value domain attributes

Representational attributes

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

Source and reference attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	Primary PCI relates to the first balloon angioplasty inflation and/or stent implantation for reperfusion therapy of a ST-segment-elevation myocardial infarction (STEMI). The time of the first balloon inflation should be recorded, even if this includes the implantation of a stent.
Comments:	This is used to calculate the time between initial presentation and reperfusion.

Source and reference attributes

Submitting organisation:	Acute coronary syndrome data working group

Relational attributes

Related metadata references:	Supersedes Person—first angioplasty balloon inflation or stenting time, hhmm Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Coronary artery cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	Record when a primary percutaneous coronary intervention is performed.

Person—reason for non prescription of pharmacotherapy, code N

Identifying and definitional attributes

Short name:	Reason for non prescription of pharmacotherapy
METeOR identifier:	347222
Registration status:	Health, Standard 01/10/2008
Definition:	The reason a pharmacotherapy was not prescribed for a person, as represented by a code.
Data Element Concept:	Person—reason for non prescription of pharmacotherapy

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Not indicated
2	Contraindicated

Supplementary values:

Value	Meaning
9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Not indicated

Record this code when a pharmacotherapy was not prescribed because it was not necessary to the treatment of the person.

CODE 2 Contraindicated

Record this code when a pharmacotherapy was not prescribed because of a condition or factor that increases the risks involved in using the pharmacotherapy. Examples of contraindications are allergy, intolerance, medical condition.

Collection methods: For each type of pharmacotherapy not prescribed for the person, record whether it was not indicated or contraindicated.

Relational attributes

Related metadata references: See also Person with acute coronary syndrome—pharmacotherapy type prescribed in hospital, code N[N] Health, Standard 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation: To be provided for each of the pharmacotherapies listed in the data element '*Pharmacotherapy type prescribed for acute coronary syndrome in hospital*' not prescribed.

Person—reason for readmission following acute coronary syndrome episode, code N[N]

Identifying and definitional attributes

Short name:	Reason for readmission—acute coronary syndrome
METeOR identifier:	359404
Registration status:	Health, Standard 01/10/2008
Definition:	The main reason for the **admission**, to any hospital, of a person within 28 days of discharge from an episode of admitted patient care for acute coronary syndrome, as represented by a code.
Data Element Concept:	Person—reason for readmission following acute coronary syndrome episode

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	ST-segment-elevation myocardial infarction
2	non-ST-segment-elevation ACS with high-risk features
3	non-ST-segment-elevation ACS with intermediate-risk features
4	non-ST-segment-elevation ACS with low-risk features
5	Percutaneous coronary intervention (PCI)
6	Coronary artery bypass graft (CABG)
7	Heart Failure (without MI)
8	Arrhythmia (without MI)

Supplementary values:

99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 ST-segment-elevation myocardial infarction

This code is used when the reason for admission is persistent ST elevation of >=1mm in two contiguous limb leads, or ST elevation of >=2mm in two contiguous chest leads, or with new left bundle-branch block (BBB) pattern on the ECG.

CODE 2 Non-ST-segment-elevation ACS with high-risk features

This code is used when the reason for admission is clinical features consistent with an acute coronary syndrome with high-risk features which include any of the following:

- repetitive or prolonged (> 10 minutes) ongoing chest pain or discomfort;
- elevated level of at least one cardiac biomarker (troponin or

creatine kinase-MB isoenzyme);

- persistent or dynamic ECG changes of ST segment depression >= 0.5mm or new T wave >= 2mm;
- transient ST-segment elevation (>= 0.5 mm) in more than 2 contiguous leads;
- haemodynamic compromise: Blood pressure < 90 mmHg systolic, cool peripheries, diaphoresis, Killip Class > 1, and/or new onset mitral regurgitation;
- sustained ventricular tachycardia;
- syncope;
- left ventricular systolic dysfunction (left ventricular ejection fraction < 0.40);
- prior percutaneous coronary intervention within 6 months or prior coronary artery bypass surgery;
- presence of known diabetes (with typical symptoms of ACS); or
- chronic kidney disease (estimated glomerular filtration rate < 60mL/minute) (with typical symptoms of ACS).

CODE 3 Non-ST-segment-elevation ACS with intermediate-risk features

This code is used when the reason for admission is clinical features consistent with an acute coronary syndrome and any of the following intermediate-risk features AND NOT meeting the criteria for high-risk ACS:

- chest pain or discomfort within the past 48 hours that occurred at rest, or was repetitive or prolonged (but currently resolved);
- age greater than 65yrs;
- known coronary heart disease: prior myocardial infarction with left ventricular ejection fraction >= 0.40, or known coronary lesion more than >50% stenosed;
- no high-risk changes on electrocardiography (see high-risk features);
- two or more of the following risk factors: of known hypertension, family history, active smoking or hyperlipidaemia;
- presence of known diabetes (with atypical symptoms of ACS);
- chronic kidney disease (estimated glomerular filtration rate < 60mL/minute) (with atypical symptoms of ACS); or
- prior aspirin use.

CODE 4 Non-ST-segment-elevation ACS with low-risk features

This code is used when the reason for admission is clinical features consistent with an acute coronary syndrome without intermediate or high-risk features of non-ST-segment-elevation ACS. This includes onset of anginal symptoms within the last month, or worsening in severity or frequency of angina, or lowering of anginal threshold.

CODE 5 Percutaneous coronary intervention (PCI)

This code is used when the reason for admission is for a PCI, where the PCI is not immediately precipitated by a recurrent ischaemic event. If a recurrent ischaemic event precipitates a readmission with an associated PCI undertaken, one of codes 1-

4 should be coded.

CODE 6 Coronary artery bypass graft (CABG)

This code is used when the reason for admission is for a CABG, where the CABG is not immediately precipitated by a recurrent ischaemic event. If a recurrent ischaemic event precipitates a readmission with an associated CABG undertaken, one of codes 1-4 should be coded.

CODE 7 Heart failure (without MI)

This code is used when the reason for admission is for the treatment of heart failure, where heart failure is not immediately precipitated by a recurrent ischaemic event. If a recurrent ischaemic event precipitates a readmission, one of codes 1-4 should be coded.

CODE 8 Arrhythmia (without MI)

This code is used when the reason for admission is for the treatment of an arrhythmia, where the arrhythmia is not immediately precipitated by a recurrent ischaemic event. If a recurrent ischaemic event precipitates a readmission, one of codes 1-4 should be coded.

Data element attributes

Collection and usage attributes

Guide for use:	To determine if this item should be collected ask the person being admitted if they have been discharged from an episode of admitted patient care for acute coronary syndrome within the last 28 days.
Comments:	This metadata item is designed to identify recurrent admissions following an initial presentation with acute coronary syndromes (ACS), not necessarily to the hospital responsible for the index admission.

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Person—reason for readmission following acute coronary syndrome episode, code N[N] Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Person—rescue percutaneous coronary intervention date, DDMMYYYY

Identifying and definitional attributes

Short name:	Date of rescue percutaneous coronary intervention
Synonymous names:	Rescue PCI date
METeOR identifier:	359580
Registration status:	Health, Standard 01/10/2008
Definition:	The date when rescue percutaneous coronary intervention (PCI) is performed.
Data Element Concept:	Person—rescue percutaneous coronary intervention date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	Rescue PCI relates to balloon angioplasty inflation and/or stent implantation performed following failed fibrinolysis in patients with continuing or recurrent myocardial ischaemia.

Source and reference attributes

Reference documents:	National Heart Foundation of Australia & Cardiac Society of Australia and New Zealand. Guidelines for the management of acute coronary syndromes 2006. Med J Aust 2006; 184; S1-S32. © MJA 2006

Relational attributes

Implementation in Data Set Specifications:	Coronary artery cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	Record when a rescue percutaneous coronary intervention is performed.

Person—rescue percutaneous coronary intervention time, hhmm

Identifying and definitional attributes

Short name:	Time of rescue percutaneous coronary intervention
Synonymous names:	Rescue PCI time
METeOR identifier:	359569
Registration status:	Health, Standard 01/10/2008
Definition:	The time when rescue percutaneous coronary intervention (PCI) is performed.
Data Element Concept:	Person—rescue percutaneous coronary intervention time

Value domain attributes

Representational attributes

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

Source and reference attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	Rescue PCI relates to balloon angioplasty inflation and/or stent implantation performed following failed fibrinolysis in patients with continuing or recurrent myocardial ischaemia.

Source and reference attributes

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

Relational attributes

Implementation in Data Set Specifications:	Coronary artery cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	Record when a rescue percutaneous coronary intervention is performed.

Person—revascularisation percutaneous coronary intervention date, DDMMYYYY

Identifying and definitional attributes

Short name:	Date of revascularisation percutaneous coronary intervention
Synonymous names:	Revascularisation PCI date
METeOR identifier:	359731
Registration status:	Health, Standard 01/10/2008
Definition:	The date when a percutaneous coronary intervention (PCI) is performed for revascularisation.
Data Element Concept:	Person—revascularisation percutaneous coronary intervention date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	Revascularisation PCI relates to balloon angioplasty inflation and/or stent implantation performed for subsequent restoration of blood flow.
Comments:	Routine revascularisation PCI may be performed after ST-segment-elevation myocardial infarction for people with objective evidence of recurrent myocardial infarction in whom there is spontaneous or inducible ischaemia or haemodynamic instability. Revascularisation PCI may also be performed for treatment of high-risk non-ST-segment-elevation acute coronary syndrome.

Source and reference attributes

Reference documents:	National Heart Foundation of Australia & Cardiac Society of Australia and New Zealand. Guidelines for the management of acute coronary syndromes 2006. Med J Aust 2006; 184; S1-S32. © MJA 2006

Relational attributes

Implementation in Data Set Specifications:	Coronary artery cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	Record when a percutaneous coronary intervention is performed for revascularisation.

Person—revascularisation percutaneous coronary intervention time, hhmm

Identifying and definitional attributes

Short name:	Time of revascularisation percutaneous coronary intervention
Synonymous names:	Revascularisation PCI time
METeOR identifier:	359738
Registration status:	Health, Standard 01/10/2008
Definition:	The time when a percutaneous coronary intervention (PCI) is performed for revascularisation.
Data Element Concept:	Person—revascularisation percutaneous coronary intervention time

Value domain attributes

Representational attributes

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

Source and reference attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	Revascularisation PCI relates to balloon angioplasty inflation and/or stent implantation performed for subsequent restoration of blood flow.
Comments:	Routine revascularisation PCI may be performed after ST-segment-elevation myocardial infarction for people with objective evidence of recurrent myocardial infarction in whom there is spontaneous or inducible ischaemia or haemodynamic instability. Revascularisation PCI may also be performed for treatment of high-risk non-ST-segment-elevation acute coronary syndrome.

Source and reference attributes

Steward:	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand
Reference documents:	National Heart Foundation of Australia & Cardiac Society of Australia and New Zealand. Guidelines for the management of acute coronary syndromes 2006. Med J Aust 2006; 184; S1-S32. © MJA 2006

Relational attributes

Implementation in Data Set	Coronary artery cluster Health, Standard 01/10/2008

Specifications:

Data set specification specific attributes

Conditional obligation:	Record when a percutaneous coronary intervention is performed for revascularisation.

Person—sex, code N

Identifying and definitional attributes

Short name:	Sex
METeOR identifier:	287316
Registration status:	Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 10/02/2006
Definition:	The biological distinction between male and female, as represented by a code.
Data Element Concept:	Person—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:

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 Housing assistance, Superseded 10/02/2006 Supersedes Person—sex, code N Health, Superseded 04/05/2005, Community services, Superseded 31/08/2005 Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN Health, Standard 01/03/2005 Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA Health, Standard 01/03/2005
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008 Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008 Admitted patient care NMDS Health, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008 Admitted patient care NMDS 2008-2009 Health, Standard 05/02/2008 Admitted patient mental health care NMDS Health, Superseded 23/10/2006 Admitted patient mental health care NMDS Health, Superseded 07/12/2005 Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008 Admitted patient mental health care NMDS 2008-2009 Health, Standard 05/02/2008 Admitted patient palliative care NMDS Health, Superseded 07/12/2005 Admitted patient palliative care NMDS 2006-2007 Health, Superseded 23/10/2006 Admitted patient palliative care NMDS 2007-08 Health, Superseded 05/02/2008 Admitted patient palliative care NMDS 2008-09 Health, Standard 05/02/2008 Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006 Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006 Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008 Alcohol and other drug treatment services NMDS 2008-2009 Health, Standard 05/02/2008 AROC inpatient data set specification Health, Candidate 14/02/2007 Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Standard 07/12/2005 Cancer (clinical) DSS Health, Candidate 14/09/2006 Cardiovascular disease (clinical) DSS Health, Superseded

15/02/2006

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

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

Child protection and support services (CPSS) client cluster Community services, Standard 30/04/2008

Child protection and support services (CPSS) sibling cluster Community services, Standard 30/04/2008

Children's Services NMDS Community services, Standard 18/12/2007

Commonwealth State/Territory Disability Agreement NMDS (July 2008) Community services, Standardisation pending 24/07/2008

Commonwealth State/Territory Disability Agreement NMDS - 1 July 2006 Community services, Standard 27/04/2007

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

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

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

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

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

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

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

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

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

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

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

Juvenile Justice NMDS Community services, Standard 27/03/2007

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

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

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

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

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

Perinatal NMDS Health, Superseded 06/09/2006

Perinatal NMDS Health, Superseded 07/12/2005

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

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

Residential mental health care NMDS 2005-2006 Health,

Superseded 07/12/2005

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

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

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

SAAP Client Collection National Minimum Data Set Community services, Standard 30/11/2007

SAAP Demand for Accommodation National Minimum Data Set Community services, Standard 30/11/2007

Person—timing of ACE-inhibitor prescription, code N

Identifying and definitional attributes

Short name:	Timing of ACE-inhibitor prescription
METeOR identifier:	349385
Registration status:	Health, Standard 01/10/2008
Definition:	The timing of care when an ACE-inhibitor is prescribed to a person, as represented by a code.
Data Element Concept:	Person—timing of ACE-inhibitor prescription

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Prior to presentation at hospital
2	First 24 hours of presentation
3	After 24 hours and before discharge
4	At discharge

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Prior to presentation at hospital

Use this code when the person has been previously prescribed an ACE-inhibitor prior to presentation at the hospital and the person is still following the prescription.

CODE 2 First 24 hours of presentation

Use this code when an ACE-inhibitor is prescribed within the first 24 hours following presentation to the hospital.

CODE 3 After 24 hours and before discharge

Use this code when an ACE-inhibitor is prescribed following the first 24 hours after presentation to the hospital and before discharge from the hospital.

CODE 4 At discharge

Use this code when an ACE-inhibitor is prescribed at discharge from the hospital.

Collection methods: Record each time an ACE-inhibitor is prescribed for the person.

Relational attributes

Implementation in Data Set Specifications: Acute coronary syndrome pharmacotherapy data cluster
Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	If prescribed, provide a phase for each time ACE-inhibitor therapy is prescribed.

Person—timing of angiotensin II receptor blocker prescription, code N

Identifying and definitional attributes

Short name:	Timing of angiotensin II receptor blocker prescription
METeOR identifier:	350421
Registration status:	Health, Standard 01/10/2008
Definition:	The timing of care when an angiotensin II receptor blocker is prescribed to a person, as represented by a code.
Data Element Concept:	Person—timing of angiotensin II receptor blocker prescription

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Prior to presentation at hospital
	2	First 24 hours of presentation
	3	After 24 hours and before discharge
	4	At discharge
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Prior to presentation at hospital

Use this code when the person has been previously prescribed an angiotensin II receptor blocker prior to presentation at the hospital and the person is still following the prescription.

CODE 2 First 24 hours of presentation

Use this code when an angiotensin II receptor blocker is prescribed within the first 24 hours following presentation to the hospital.

CODE 3 After 24 hours and before discharge

Use this code when an angiotensin II receptor blocker is prescribed following the first 24 hours after presentation to the hospital and before discharge from the hospital.

CODE 4 At discharge

Use this code when an angiotensin II receptor blocker is prescribed at discharge from the hospital.

Collection methods: Record each time an angiotensin II receptor blocker is prescribed for the person.

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	If prescribed, provide a phase for each time angiotensin II receptor blocker therapy is prescribed.

Person—timing of antithrombin therapy prescription, code N

Identifying and definitional attributes

Short name:	Timing of antithrombin therapy prescription
METeOR identifier:	350510
Registration status:	Health, Standard 01/10/2008
Definition:	The timing of care when antithrombin therapy is prescribed to a person, as represented by a code.
Data Element Concept:	Person—timing of antithrombin therapy prescription

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Initial medical management: preceding reperfusion therapy
2	During reperfusion therapy
3	Following reperfusion therapy

Supplementary values:

9	Not stated/inadequately described

Source and reference attributes

Reference documents:	National Heart Foundation of Australia and Cardiac Society of Australia and New Zealand, Guidelines for the management of acute coronary syndromes 2006, Med J Aust; 184; S1-S32. © MJA2006.

Data element attributes

Collection and usage attributes

Guide for use:

Reperfusion therapy includes percutaneous coronary intervention and fibrinolytic therapy.

CODE 1 Initial medical management: preceding reperfusion therapy

Use this code when antithrombin therapy is prescribed before reperfusion therapy is to be performed.

CODE 2 During reperfusion therapy

Use this code when antithrombin therapy is prescribed while reperfusion therapy is being performed.

CODE 3 Following reperfusion therapy

Use this code when antithrombin therapy is prescribed after reperfusion therapy has been performed.

Collection methods: Record for each time antithrombin therapy is prescribed for the

person.

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	If prescribed, provide a phase for each time antithrombin therapy is prescribed

Person—timing of aspirin prescription, code N

Identifying and definitional attributes

Short name:	Timing of aspirin prescription
METeOR identifier:	347829
Registration status:	Health, Standard 01/10/2008
Definition:	The timing of care when aspirin is prescribed to a person, as represented by a code.
Data Element Concept:	Person—timing of aspirin prescription

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Prior to presentation at hospital
2	First 24 hours of presentation
3	After 24 hours and before discharge
4	At discharge

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Prior to presentation at hospital

Use this code when the person has been previously prescribed aspirin prior to presentation at the hospital and the person is still following the prescription.

CODE 2 First 24 hours of presentation

Use this code when aspirin is prescribed within the first 24 hours following presentation to the hospital.

CODE 3 After 24 hours and before discharge

Use this code when aspirin is prescribed following the first 24 hours after presentation to the hospital and before discharge from the hospital.

CODE 4 At discharge

Use this code when aspirin is prescribed at discharge from the hospital.

Collection methods: Record each time aspirin is prescribed for the person.

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	If prescribed, provide a phase for each time aspirin therapy is prescribed.

Person—timing of beta-blocker prescription, code N

Identifying and definitional attributes

Short name:	Timing of beta-blocker prescription
METeOR identifier:	349400
Registration status:	Health, Standard 01/10/2008
Definition:	The timing of care when a beta-blocker is prescribed to a person, as represented by a code.
Data Element Concept:	Person—timing of beta-blocker prescription

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Prior to presentation at hospital
2	First 24 hours of presentation
3	After 24 hours and before discharge
4	At discharge

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Prior to presentation at hospital

Use this code when the person has been previously prescribed a beta-blocker prior to presentation at the hospital and the person is still following the prescription.

CODE 2 First 24 hours of presentation

Use this code when a beta-blocker is prescribed within the first 24 hours following presentation to the hospital.

CODE 3 After 24 hours and before discharge

Use this code when a beta-blocker is prescribed following the first 24 hours after presentation to the hospital and before discharge from the hospital.

CODE 4 At discharge

Use this code when a beta-blocker is prescribed at discharge from the hospital.

Collection methods: Record each time a beta-blocker is prescribed for a person.

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	If prescribed, provide a phase for each time beta-blocker therapy is prescribed.

Person—timing of clopidogrel prescription, code N

Identifying and definitional attributes

Short name:	Timing of clopidogrel prescription
METeOR identifier:	350431
Registration status:	Health, Standard 01/10/2008
Definition:	The timing of care when clopidogrel is prescribed to a person, as represented by a code.
Data Element Concept:	Person—timing of clopidogrel prescription

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Prior to presentation at hospital
2	First 24 hours of presentation
3	After 24 hours and before discharge
4	At discharge

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Prior to presentation at hospital

Use this code when the person has been previously prescribed clopidogrel prior to presentation at the hospital and the person is still following the prescription.

CODE 2 First 24 hours of presentation

Use this code when clopidogrel is prescribed within the first 24 hours following presentation to the hospital.

CODE 3 After 24 hours and before discharge

Use this code when clopidogrel is prescribed following the first 24 hours after presentation to the hospital and before discharge from the hospital.

CODE 4 At discharge

Use this code when clopidogrel is prescribed at discharge from the hospital.

Collection methods: Record each time clopidogrel is prescribed for the person.

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	If prescribed, provide a phase for each time clopidogrel therapy is prescribed.

Person—timing of glycoprotein IIb/IIIa inhibitor prescription, code N

Identifying and definitional attributes

Short name:	Timing of glycoprotein IIb/IIIa inhibitor prescription
METeOR identifier:	349367
Registration status:	Health, Standard 01/10/2008
Definition:	The timing of care when a glycoprotein IIb/IIIa inhibitor is prescribed to a person, as represented by a code.
Data Element Concept:	Person—timing of glycoprotein IIb/IIIa inhibitor prescription

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Initial medical management: preceding invasive management
2	During invasive management
3	Following invasive management

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

Invasive management includes angiography, percutaneous coronary intervention and coronary artery bypass graft.

CODE 1 Initial medical management: preceding invasive management

Use this code when a glycoprotein IIb/IIIa inhibitor is prescribed before invasive management is to be performed.

CODE 2 During invasive management

Use this code when a glycoprotein IIb/IIIa inhibitor is prescribed while invasive management is being performed.

CODE 2 Following invasive management

Use this code when a glycoprotein IIb/IIIa inhibitor is prescribed after invasive management has been performed.

Collection methods: Record each time a glycoprotein IIb/IIIa inhibitor is prescribed for a person.

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	If prescribed, provide a phase for each time glycoprotein IIb/IIIa inhibitor therapy is prescribed.

Person—timing of statin prescription, code N

Identifying and definitional attributes

Short name:	Timing of statin prescription
METeOR identifier:	350445
Registration status:	Health, Standard 01/10/2008
Definition:	The timing of care when a statin is prescribed to a person, as represented by a code.
Data Element Concept:	Person—timing of statin prescription

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Prior to presentation at hospital
2	First 24 hours of presentation
3	After 24 hours and before discharge
4	At discharge

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Prior to presentation at hospital

Use this code when the person has been previously prescribed a statin prior to presentation at the hospital and the person is still following the prescription.

CODE 2 First 24 hours of presentation

Use this code when a statin is prescribed for within the first 24 hours following presentation to the hospital.

CODE 3 After 24 hours and before discharge

Use this code when an ACE-inhibitor is prescribed following the first 24 hours after presentation to the hospital and before discharge from the hospital.

CODE 4 At discharge

Use this code when a statin is prescribed at discharge from the hospital.

Collection methods: Record each time a statin is prescribed for the person.

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	If prescribed, provide a phase for each time statin therapy is prescribed.

Person—tobacco smoking status, code N

Identifying and definitional attributes

Short name:	Tobacco smoking status
METeOR identifier:	270311
Registration status:	Health, Standard 01/03/2005
Definition:	A person's current and past smoking behaviour, as represented by a code.
Context:	Public health and health care
Data Element Concept:	Person—tobacco smoking status

Value domain attributes

Representational attributes

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

Permissible values:

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

Collection and usage attributes

Guide for use:

CODE 1 Daily smoker

A person who smokes daily

CODE 2 Weekly smoker

A person who smokes at least weekly but not daily

CODE 3 Irregular smoker

A person who smokes less than weekly

CODE 4 Ex-smoker

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

CODE 5 Never-smoker

A person who does not smoke now and has smoked fewer than 100 cigarettes or similar amount of other tobacco products in his/her lifetime.

Source and reference attributes

Reference documents:	Standard Questions on the Use of Tobacco Among Adults (1998)

Data element attributes

Collection and usage attributes

Collection methods:

The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults - interviewer administered (Questions 1 and 4) and self-administered (Questions 1 and 1a) versions. The questionnaires are designed to cover persons aged 18 years and over.

Comments:

There are two other ways of categorising this information:

- Regular and irregular smokers where a regular smoker includes someone who is a daily smoker or a weekly smoker. 'Regular' smoker is the preferred category to be reported in prevalence estimates.
- Daily and occasional smokers where an occasional smoker includes someone who is a weekly or irregular smoker. The category of 'occasional' smoker can be used when the aim of the study is to draw contrast between daily smokers and other smokers.
  Where this information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

Smoker type is used to define subpopulations of adults (age 18+ years) based on their smoking behaviour.

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

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

- To evaluate health promotion and disease prevention programs (assessment of interventions)
- To monitor health risk factors and progress towards National Health Goals and Targets

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

Relational attributes

Related metadata references:

Supersedes Tobacco smoking status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.55 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008

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

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

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

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

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

Data set specification specific attributes

Information specific to this data set:

Smoker type is used to define sub-populations of adults (age 18+ years) based on their smoking behaviour. Smoking has long been known as a health risk factor. Population studies indicate a relationship between smoking and increased mortality/morbidity. This metadata item can be used to estimate smoking prevalence.

Other uses are:

- To evaluate health promotion and disease prevention programs (assessment of interventions)
- To monitor health risk factors and progress towards National Health Goals and Targets

Person—triglyceride level (measured), total millimoles per litre N[N].N

Identifying and definitional attributes

Short name:	Triglyceride level (measured)
METeOR identifier:	359411
Registration status:	Health, Standard 01/10/2008
Definition:	A person's triglyceride level measured in millimoles per litre.
Data Element Concept:	Person—triglyceride level

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
99.9	Not stated/inadequately described.

Unit of measure: Millimole per litre (mmol/L)

Data element attributes

Collection and usage attributes

Guide for use: Record the absolute result of the total triglyceride measurement.

Collection methods: Measurement of lipid levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authorities.

- To be collected as a single venous blood sample, preferably following a 12-hour fast where only water and medications have been consumed.

Note that to calculate the low-density lipoprotein - cholesterol (LDL-C) from the Friedwald Equation (Friedwald et al, 1972):

- a fasting level of plasma triglyceride and knowledge of the levels of plasma total cholesterol and high-density lipoprotein - cholesterol (HDL-C) is required,
- the Friedwald equation becomes unreliable when the plasma triglyceride exceeds 4.5 mmol/L, and
- that while levels are reliable for the first 24 hours after the onset of acute coronary syndromes, they may be unreliable for the subsequent 8 weeks after an event.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Relational attributes

Related metadata references: Supersedes Person—triglyceride level (measured), total

	millimoles per litre N[N].N Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Person—troponin assay type, code N

Identifying and definitional attributes

Short name:	Troponin assay type
METeOR identifier:	356929
Registration status:	Health, Standard 01/10/2008
Definition:	The type of troponin assay (I or T) used to assess the person's troponin levels, as represented by a code.
Data Element Concept:	Person—troponin assay type

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Cardiac troponin T (cTnT)
	2	Cardiac troponin I (cTnI)
Supplementary values:	9	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Person—troponin assay type, code N Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Data set specification specific attributes

Information specific to this data set:	For Acute coronary syndrome (ACS) reporting, record the type of troponin assay (I or T) used to assess troponin levels during this presentation.

Person—troponin level (measured), total micrograms per litre NN.NN

Identifying and definitional attributes

Short name:	Troponin level (measured)
METeOR identifier:	356934
Registration status:	Health, Standard 01/10/2008
Definition:	A person's troponin measured in micrograms per litre.
Data Element Concept:	Person—troponin level

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
88.88	Not measured
99.99	Not stated/inadequately described

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

Collection and usage attributes

Guide for use: CODE 88.88 Not measured

This code is used if test for troponin (T or I) was not done.

Data element attributes

Collection and usage attributes

Guide for use: Measured in different assays dependant upon laboratory methodology.

When only one troponin level is recorded, this should be the peak level.

Source and reference attributes

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

Relational attributes

Related metadata references: See also Laboratory standard—upper limit of normal range for troponin assay, total micrograms per litre N[NNN] Health, Superseded 01/10/2008

Supersedes Person—troponin level (measured), total micrograms per litre NN.NN Health, Superseded 01/10/2008

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Data set specification specific attributes

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

Person—troponin level measured date, DDMMYYYY

Identifying and definitional attributes

Short name:	Date troponin measured
METeOR identifier:	359422
Registration status:	Health, Standard 01/10/2008
Definition:	Date the person's troponin assay is measured.
Data Element Concept:	Person—troponin level measured date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Person—troponin level measured date, DDMMYYYY Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Person—troponin level measured time, hhmm

Identifying and definitional attributes

Short name:	Time troponin measured
METeOR identifier:	359427
Registration status:	Health, Standard 01/10/2008
Definition:	The time at which the troponin (T or I) was measured.
Data Element Concept:	Person—troponin level measured time

Value domain attributes

Representational attributes

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

Source and reference attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Person—troponin level measured time, hhmm Health, Superseded 01/10/2008
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Person—underlying cause of death, code (ICD-10 2nd edn) ANN-ANN

Identifying and definitional attributes

Short name:	Underlying cause of death
Synonymous names:	UCOD code
METeOR identifier:	307931
Registration status:	Health, Standard 01/10/2008
Definition:	The disease or injury which initiated the train of morbid events leading directly to a person's death or the circumstances of the accident or violence which produced the fatal injury, as represented by a code. (WHO 2004)
Data Element Concept:	Person—underlying cause of death

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, (2nd edition)
Representation class:	Code
Data type:	String
Format:	ANN-ANN
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:	Underlying cause of death is central to mortality coding and comparable international mortality reporting.
Comments:	The Australian Bureau of Statistics (ABS), codes and classifies the underlying cause of death (UCOD) according to the rules and guidelines for mortality coding adopted by the World Health Assembly and set out in the World Health Organisation's International Classification of Diseases and Related Health Problems (ICD). The ABS (Australian Bureau of Statistics) uses the Mortality Medical Data System (MMDS)to process and code cause-of-death information reported on death certificates.

Source and reference attributes

Submitting organisation:	Australian Bureau of Statistics
Origin:	Australian Bureau of Statistics 2004. Information Paper: Cause of death certification. Catalogue no. 1205.0.55.001. Canberra: Australian Bureau of Statistics. viewed 31, August 2005. National Center for Health Statistics 2005. About the Mortality Medical Data System. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Viewed 31, August 2005, World Health Organisation 2004. The International statistical classification of diseases and related health problems, tenth

revision, (2nd edn). Geneva: World Health Organisation.

Reference documents:

Australian Bureau of Statistics 2004. Information Paper: Cause of death certification. Catalogue no. 1205.0.55.001. Canberra: Australian Bureau of Statistics. viewed 31, August 2005.

World Health Organisation 2004. The International statistical classification of diseases and related health problems, tenth revision, (2nd edn). Geneva: World Health Organisation.

Relational attributes

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:

If a date of death is recorded, the cause of death must also be recorded. These data are recorded regardless of the cause of death.

Person—units of blood transfused, total N[NNN]

Identifying and definitional attributes

Short name:	Total blood units transfused
METeOR identifier:	344798
Registration status:	Health, Standard 01/10/2008
Definition:	The total number of units of blood that a person has received, either whole blood or packed red blood cells.
Data Element Concept:	Person—units of blood transfused

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
9999	Not stated/inadequately described

Collection and usage attributes

Guide for use:	1 blood unit (or one bag of blood) = approx 500ml of blood

Data element attributes

Collection and usage attributes

Guide for use:	Platelet transfusions or transfusions of fresh frozen plasma (FFP) should not be included in the total.

Relational attributes

Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	Record the total number of blood units (either whole blood or packed red blood cells) that the person has received following a haemorrhagic event.

Person—vascular condition status (history), code NN

Identifying and definitional attributes

Short name:	Vascular history
METeOR identifier:	269958
Registration status:	Health, Standard 01/03/2005
Definition:	Whether the person has had a history of vascular conditions, as represented by a code.
Context:	The vascular history of the patient is important as an element in defining future risk for a cardiovascular event and as a factor in determining best practice management for various cardiovascular risk factor(s). It may be used to map vascular conditions, assist in risk stratification and link to best practice management.
Data Element Concept:	Person—vascular condition status

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
01	Myocardial infarction
02	Unstable angina pectoris
03	Angina
04	Heart failure
05	Atrial fibrillation
06	Other dysrhythmia or conductive disorder
07	Rheumatic heart disease
08	Non-rheumatic valvular heart disease
09	Left ventricular hypertrophy
10	Stroke
11	Transient ischaemic attack
12	Hypertension
13	Peripheral vascular disease (includes abdominal aortic aneurism)
14	Deep vein thrombosis
15	Other atherosclerotic disease
16	Carotid stenosis
17	Vascular renal disease
18	Vascular retinopathy (hypertensive)
19	Vascular retinopathy (diabetic)
97	Other vascular
98	No vascular history

Supplementary values:	99	Unknown/not stated /not specified

Collection and usage attributes

Comments: Can be mapped to the current version of ICD-10-AM.

Source and reference attributes

Origin: International Classification of Diseases - Tenth Revision - Australian Modification (3rd Edition 2000), National Centre for Classification in Health, Sydney

Data element attributes

Collection and usage attributes

Guide for use: More than one code can be recorded.

Collection methods: Ideally, vascular history information is derived from and substantiated by clinical documentation.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Origin: National Centre for Classification in Health

National Data Standards for Injury Surveillance Advisory Group

Relational attributes

Related metadata references: Supersedes Vascular history, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.83 KB)

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008

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

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

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

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

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

Person—ventricular ejection fraction test performed indicator, yes/no code N

Identifying and definitional attributes

Short name:	Ventricular ejection fraction measurement indicator
Synonymous names:	EF measurement indicator
METeOR identifier:	347672
Registration status:	Health, Standard 01/10/2008
Definition:	An indicator of whether a person's ventricular ejection fraction was measured, as represented by a code.
Data Element Concept:	Person—ventricular ejection fraction test performed indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 9 Not stated/inadequately described

This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:

Code 1 Yes

Record if a test was performed to measure the person's ventricular ejection fraction.

Code 2 No

Record if no test was performed to measure the person's ventricular ejection fraction.

Relational attributes

Related metadata references:	See also Ventricular ejection fraction test—test type, code N Health, Standard 01/10/2008
Implementation in Data Set Specifications:	Ventricular ejection fraction cluster Health, Standard 01/10/2008

Person—weight (measured), total kilograms N[NN].N

Identifying and definitional attributes

Short name:	Weight in kilograms (measured)
Synonymous names:	Infant weight, neonate, stillborn
METeOR identifier:	270208
Registration status:	Health, Standard 01/03/2005
Definition:	The weight (body mass) of a person measured in kilograms.
Data Element Concept:	Person—weight

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NN].N
Maximum character length:	4
Supplementary values:	Value — Meaning 999.9 — Not collected
Unit of measure:	Kilogram (Kg)

Collection and usage attributes

Guide for use:	A continuous variable measured to the nearest 0.1 kg. CODE 999.9 Not collected Use this code if measured weight is not collected.

Data element attributes

Collection and usage attributes

Guide for use:	In order to ensure consistency in measurement, the measurement protocol described under Collection methods should be used.
Collection methods:	The collection of anthropometric measurements, particularly in those who are overweight or obese or who are concerned about their weight, should be performed with great sensitivity and without drawing attention to an individual's weight. The measurement protocol described below is that recommended by the WHO Expert Committee (1995). Measurement protocol: Equipment used should be described and reported. Scales should have a resolution of at least 0.1kg and should have the capacity to weigh up to at least 200 kg. Measurement intervals and labels should be clearly readable under all conditions of use of the instrument. Scales should be capable of being calibrated across the entire range of measurements. Precision error should be no more than 0.1kg. Scales should be calibrated on each day of use. Manufacturers' guidelines should be followed with regard to the transportation of the scales. Adults and children who can stand:

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

Heavy jewellery should be removed and pockets emptied. Light indoor clothing can be worn, excluding shoes, belts, and sweater. Any variations from light indoor clothing (e.g. heavy clothing, such as kaftans or coats worn because of cultural practices) should be noted on the data collection form. Adjustments for non-standard clothing (i.e. other than light indoor clothing) should only be made in the data checking/cleaning stage prior to data analysis.

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

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

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

Infants:

Birth weight and gender should be recorded with gestational age. During infancy a levelled pan scale with a bean and movable weights or digital scales capable of measuring to two decimal places of a kilogram are acceptable. Birth weight should be determined within 12 hours of birth. The infant, with or without a nappy or diaper is placed on the scales so that the weight is distributed equally about the centre of the pan. When the infant is lying or suspended quietly, weight is recorded to the nearest 10 grams. If the nappy or diaper is worn, its weight is subtracted from the observed weight i.e. reference data for infants are based on nude weights.

Validation and quality control measures:

If practical, equipment should be checked daily using one or more objects of known weight in the range to be measured. It is recommended that the scale be calibrated at the extremes and in the mid range of the expected weight of the population being studied.

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

within observers.

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

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

Comments:

This metadata item applies to persons of all ages. It is recommended for use in population surveys and health care settings.

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

Metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

Presentation of data:

Means and 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. However 5-year age groups are not generally suitable for children and adolescents. Estimates based on sample surveys may need to take into account sampling weights.

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

For some reporting purposes, it may be desirable to present weight data in categories. It is recommended that 5 kg groupings are used for this purpose. Weight data should not be rounded before categorisation. The following categories may be appropriate for describing the weights of Australian men, women, children and adolescents, although the range will depend on the population.

Weight

10 kg = Weight

15 kg = Weight

... in 5 kg categories

135 kg = Weight

Weight => 140 kg

Source and reference attributes

Submitting organisation:

World Health Organization The consortium to develop standard methods for the collection and collation of anthropometric data in children as part of the National Food and Nutrition Monitoring and Surveillance Project, funded by the Commonwealth Department of Health and Ageing

Reference documents:

Clinical Guidelines on the Identification, Evaluation and

Treatment of Overweight and Obesity in Adults (US National Heart, Lung and Blood Institute (NHLBI) in cooperation with the National Institute of Diabetes and Digestive and Kidney Diseases).
Chronic Diseases and Associated Risk Factors in Australia 2001 (AIHW).

Relational attributes

Related metadata references:

Supersedes Weight - measured, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (29.31 KB)

Is used in the formation of Adult—body mass index (measured), ratio NN[N].N[N] Health, Standard 01/03/2005

Is used in the formation of Child—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005

Is used in the formation of Child—body mass index (measured), ratio NN[N].N[N] Health, Standard 01/03/2005

Is used in the formation of Adult—body mass index (self-reported), ratio NN[N].N[N] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

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

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

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

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

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

Ventricular ejection fraction test—test date, DDMMYYYY

Identifying and definitional attributes

Short name:	Date of ventricular ejection fraction test
Synonymous names:	Date EF measured
METeOR identifier:	344274
Registration status:	Health, Standard 01/10/2008
Definition:	The date when a person's ventricular ejection fraction is measured.
Data Element Concept:	Ventricular ejection fraction test—test date

Value domain attributes

Representational attributes

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

Data element attributes

Relational attributes

Implementation in Data Set Specifications:	Ventricular ejection fraction cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	To be provided when the ventricular ejection fraction is measured.

Ventricular ejection fraction test—test time, hhmm

Identifying and definitional attributes

Short name:	Time of ventricular ejection fraction test
Synonymous names:	Time EF measured
METeOR identifier:	349817
Registration status:	Health, Standard 01/10/2008
Definition:	The time when a person's ventricular ejection fraction is measured.
Data Element Concept:	Ventricular ejection fraction—test time

Value domain attributes

Representational attributes

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

Source and reference attributes

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

Data element attributes

Relational attributes

Implementation in Data Set Specifications:	Ventricular ejection fraction cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	To be provided when the ventricular ejection fraction is measured.

Ventricular ejection fraction test—test type, code N

Identifying and definitional attributes

Short name:	Ventricular ejection fraction test type
Synonymous names:	EF measurement test
METeOR identifier:	344253
Registration status:	Health, Standard 01/10/2008
Definition:	The type of test used to measure a person's ventricular ejection fraction, as represented by a code.
Data Element Concept:	Ventricular ejection fraction test—test type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Echocardiography
2	Angiography
3	Gated blood pool scan
4	Magnetic resonance imaging (MRI)

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Relational attributes

Related metadata references:	See also Person—ventricular ejection fraction test performed indicator, yes/no code N Health, Standard 01/10/2008
Implementation in Data Set Specifications:	Ventricular ejection fraction cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	To be provided when the ventricular ejection fraction is measured.

Ventricular ejection fraction—test result, code N

Identifying and definitional attributes

Short name:	Ventricular ejection fraction test result (code)
Synonymous names:	EF result (code)
METeOR identifier:	346993
Registration status:	Health, Standard 01/10/2008
Definition:	The person's ventricular ejection fraction result, as represented by a code.
Data Element Concept:	Ventricular ejection fraction—test result

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Normal
2	Mild
3	Moderate
4	Severe

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Normal

Use this code when the ejection fraction is greater than 50%

CODE 2 Mild

Use this code when the ejection fraction is greater than or equal to 45% but less than or equal to 50%

CODE 3 Moderate

Use this code when the ejection fraction is greater than or equal to 35% but less than 45%

CODE 4 Severe

Use this code when the ejection fraction is less than 35%

CODE 9 Not stated/inadequately described

Not for use in primary data collections.

Data element attributes

Relational attributes

Related metadata references:	See also Ventricular ejection fraction—test result, percentage N[N].N Health, Standard 01/10/2008
Implementation in Data Set Specifications:	Ventricular ejection fraction cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	To be provided when the ventricular ejection fraction is measured.

Ventricular ejection fraction—test result, percentage N[N].N

Identifying and definitional attributes

Short name:	Ventricular ejection fraction test result (percentage)
Synonymous names:	EF result (percentage)
METeOR identifier:	347002
Registration status:	Health, Standard 01/10/2008
Definition:	A person's ventricular ejection fraction result expressed as a percentage.
Data Element Concept:	Ventricular ejection fraction—test result

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
99.9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:	The person's ejection fraction result recorded should be between 0 and 80%.
Comments:	The patient is not alive or is in Pulseless Electrical Activity (PEA) if the result is 0%.

Relational attributes

Related metadata references:	See also Ventricular ejection fraction—test result, code N Health, Standard 01/10/2008
Implementation in Data Set Specifications:	Ventricular ejection fraction cluster Health, Standard 01/10/2008

Data set specification specific attributes

Conditional obligation:	To be provided when the ventricular ejection fraction is measured.