National Health Data Dictionary Version 13.2 Volume 4 Data elements M to Q

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Data Elements

Main language other than English spoken at home

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Person—main language other than English spoken at home
Definition:	The language reported by a person as the main language other than English spoken by that person in his/her home (or most recent private residential setting occupied by the person) to communicate with other residents of the home or setting and regular visitors.
Object class:	Person
Property:	Main language other than English spoken at home

Value domain attributes

Representational attributes

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

Collection and usage attributes

Guide for use:	The Australian Standard Classification of Languages (ASCL) has a three- level hierarchical structure. The most detailed level of the classification consists of base units (languages) which are represented by four-digit codes. The second level of the classification comprises narrow groups of languages (the Narrow Group level), identified by the first two digits. The most general level of the classification consists of broad groups of languages (the Broad Group level) and is identified by the first digit. The classification includes Australian Indigenous languages and sign languages. For example, the Lithuanian language has a code of 3102. In this case 3 denotes that it is an Eastern European language, while 31 denotes that it is a Baltic language. The Pintupi Aboriginal language is coded as 8713. In this case 8 denotes that it is an Australian Indigenous language and 87 denotes that the

language is Western Desert language.

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

Data element attributes

Collection and usage attributes

Collection methods:

Recommended question:

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

No (English only) ____

Yes, Italian ____

Yes, Greek ____

Yes, Cantonese ____

Yes, Mandarin ____

Yes, Arabic ____

Yes, Vietnamese ____

Yes, German ____

Yes, Spanish

Yes, Tagalog (Filipino) ____

Yes, Other (please specify) _____

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

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

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

Comments:

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

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

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

Source and reference attributes

Origin:

Health Data Standards Committee

National Community Services Data Committee

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

Relational attributes

Related metadata references:

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

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

Main occupation of person

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Person—occupation (main)
Definition:	The job in which the person is principally engaged.
Object class:	Person
Property:	Occupation

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

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

code from the ANZSCO at any of the available levels (see Guide for use section).

If only one question is asked, question one should be used. The use of question one only, however, sometimes elicits responses which do not provide a clear occupation title and specification of tasks performed. As a result accurate coding at unit group or occupation level may not be possible.

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

Comments:

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

National Health Data Dictionary (NHDD) specific:

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

Source and reference attributes

Origin:

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

Relational attributes

Related metadata references:

Supersedes Person—occupation (main), code (ASCO 2nd edn) N[NNN]{-NN} NHIG, Superseded 04/07/2007, NCSIMG, Superseded 27/03/2007, NHDAMG, Standard 10/02/2006

See also Person—labour force status, code N NHIG, Standard 01/03/2005, NCSIMG, Standard 01/03/2005, NHDAMG, Standard 01/03/2005

Main treatment type for alcohol and other drugs

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Episode of treatment for alcohol and other drugs—treatment type
Definition:	The type of treatment provided to a client during an episode of treatment for alcohol and other drugs.
Context:	Alcohol and other drug treatment services
Object class:	Episode of treatment for alcohol and other drugs
Property:	Treatment type

Value domain attributes

Representational attributes

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

Permissible values:

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

Collection and usage attributes

Guide for use:

CODE 1 Withdrawal management (detoxification)

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

CODE 2 Counselling

This code refers to any method of individual or group counselling directed towards identified problems with alcohol and/or other drug use or dependency. This code excludes

counselling activity that is part of a rehabilitation program as defined in Code 3.

CODE 3 Rehabilitation

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

CODE 4 Pharmacotherapy

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

CODE 5 Support and case management only

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

CODE 6 Information and education only

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

CODE 7 Assessment only

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

Data element attributes

Collection and usage attributes

Guide for use:

Only one code to be selected.

To be completed at assessment or commencement of treatment.

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

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

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

Source and reference attributes

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

Relational attributes

Related metadata references: Supersedes Main treatment type for alcohol and other drugs, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Implementation in Data Set Specifications: Alcohol and other drug treatment services NMDS NHIG, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Major diagnostic category

Identifying and definitional attributes

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

Data element concept attributes

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

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use: Version effective 1 July each year

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

Source and reference attributes

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

Relational attributes

Related metadata references:

Is formed using Episode of care—mental health legal status, code N NHIG, Standard 01/03/2005

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

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

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

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

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

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

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

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

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

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

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

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

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

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Marital status

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Person—marital status
Definition:	A person's current relationship status in terms of a couple relationship or, for those not in a couple relationship, the existence of a current or previous registered marriage.
Context:	Marital status is a core metadata item in a wide range of social, labour and demographic statistics. Its main purpose is analysis of the association of marital status with the need for and use of services, and for epidemiological analysis. Marital status also acts as an indicator for the level of support adult recipients of the welfare system have at home. The item is also used in comparisons of administrative data and population censuses and surveys.
Object class:	Person
Property:	Marital status

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Never married
2	Widowed
3	Divorced
4	Separated
5	Married (registered and de facto)

Supplementary values:

6	Not stated/inadequately described

Collection and usage attributes

Guide for use:	Refers to the current marital status of a person. CODE 2 Widowed

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

CODE 4 Separated

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

CODE 5 Married (registered and de facto)

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

CODE 6 Not stated / inadequately described

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

Source and reference attributes

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

Data element attributes

Collection and usage attributes

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

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

Yes, in a registered marriage

Yes, in a defacto marriage

No, never married

No, separated

No, divorced

No, widowed

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

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

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

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

It is recommended that the social marital status concept be

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

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

Source and reference attributes

Origin: National Health Data Standards Committee

National Community Services Data Committee

Relational attributes

Related metadata references: Supersedes Person—marital status, code N NHIG, Superseded 04 / 05 / 2005, NCSIMG, Superseded 25 / 08 / 2005

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

Implementation start date: 01 / 07 / 2005

Implementation end date: 30 / 06 / 2006

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

Implementation start date: 01 / 07 / 2006

Implementation end date: 30 / 06 / 2007

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

Implementation start date: 01 / 07 / 2007

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

Implementation start date: 01 / 07 / 2004

Implementation end date: 30 / 06 / 2005

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

Implementation start date: 01 / 07 / 2005

Implementation end date: 30 / 06 / 2006

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

Implementation start date: 01 / 07 / 2006

Implementation end date: 30 / 06 / 2007

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

Implementation start date: 01 / 07 / 2007

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

Information specific to this data set:
For data collection using Computer Assisted Telephone Interviewing (CATI) the recommended question is:

Which of the following best describes your current marital

status?

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

Married

Living with partner

Widowed

Divorced

Separated

Never married

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

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

Implementation start date: 01 / 07 / 2005

Implementation end date: 30 / 06 / 2006

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

Implementation start date: 01 / 07 / 2006

Implementation end date: 30 / 06 / 2007

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

Implementation start date: 01 / 07 / 2007

Maternal medical conditions

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female (pregnant)—maternal medical condition, code (ICD-10-AM 5th edn) ANN{.N[N]}
METeOR identifier:	333843
Registration status:	NHIG, Standard 07/12/2005
Definition:	Pre-existing maternal diseases and conditions, and other diseases, illnesses or conditions arising during the current pregnancy, that are not directly attributable to pregnancy but may significantly affect care during the current pregnancy and/or pregnancy outcome, as represented by a code.
Context:	Perinatal statistics

Data element concept attributes

Data element concept:	Female (pregnant)—maternal medical condition
Definition:	Diseases, conditions or illnesses associated with a pregnant female.
Object class:	Female
Property:	Maternal medical condition

Value domain attributes

Representational attributes

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

Collection and usage attributes

Guide for use:	Complications and conditions should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM.

Data element attributes

Collection and usage attributes

Guide for use:	Examples of such conditions include essential hypertension, psychiatric disorders, diabetes mellitus, epilepsy, cardiac disease and chronic renal disease. There is no arbitrary limit on the number of conditions specified.

Comments: Maternal medical conditions may influence the course and outcome of the pregnancy and may result in antenatal admission to hospital and / or treatment that could have adverse effects on the fetus and perinatal morbidity.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Origin: International Classification of Diseases - Tenth Revision - Australian Modification (5th Edition 2005) National Centre for Classification in Health, Sydney.

Relational attributes

Related metadata references: Supersedes Female (pregnant)—maternal medical condition, code (ICD-10-AM 4th edn) ANN{.N[N]} NHIG, Superseded 07 / 12 / 2005

Medicare card number

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Person—government funding identifier
Definition:	A personal identifier allocated by a government department for the purpose of identifying those eligible for specific services.
Object class:	Person
Property:	Government funding identifier

Value domain attributes

Representational attributes

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

Collection and usage attributes

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

Data element attributes

Collection and usage attributes

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

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

Source and reference attributes

Submitting organisation: Standards Australia

Origin: AS5017 Health care client identification

Relational attributes

Related metadata references: Supersedes Medicare card number, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005

Implementation in Data Set Specifications: Cancer (clinical) DSS NHIG, Superseded 07/12/2005

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

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

Implementation start date: 01/01/2003

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

Medicare eligibility status

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Person—eligibility status
Definition:	An indicator of a person's eligibility to receive a service as determined by an assessment.
Object class:	Person
Property:	Eligibility status

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Eligible
2	Not eligible

Supplementary values:

9	Not stated/unknown

Data element attributes

Collection and usage attributes

Guide for use:

Eligible persons are

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

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

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

- Foreign spouses of Australian residents:

- must have an application for permanent residence, as above

- Asylum seekers who have been issued with valid temporary visas. The list of visas is subject to changes which may be applied by the Department of Immigration and Multicultural Affairs.
- American Fulbright scholars studying in Australia (but not their dependents)
- Diplomats and their dependants from reciprocal health countries (excluding New Zealand and Norway) have full access to Medicare without the restrictions for American Fulbright scholars.

Reciprocal health care agreements

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

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

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

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

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

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

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

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

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

Relational attributes

Related metadata references:	Supersedes Person—eligibility status, Medicare code N NHIG, Superseded 04/07/2007

Mental health legal status

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Episode of care—mental health legal status
Definition:	Whether a person is treated on an involuntary basis under the relevant state or territory mental health legislation, at any time during an episode of admitted patient care, an episode of residential care or treatment of a patient/client by a community based service during a reporting period. Involuntary patients are persons who are detained in hospital or compulsorily treated in the community under mental health legislation for the purpose of assessment or provision of appropriate treatment or care.
Context:	Mental health care: This metadata item is required to monitor trends in the use of compulsory treatment provisions under State and Territory mental health legislation by Australian hospitals and community health care facilities, including 24-hour community based residential services. For those hospitals and community mental health services which provide psychiatric treatment to involuntary patients, mental health legal status information is an essential metadata item within local record systems.
Object class:	Episode of care
Property:	Mental health legal status

Collection and usage attributes

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

Value domain attributes

Representational attributes

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

Permissible values:	Value	Meaning
	1	Involuntary patient
	2	Voluntary patient
Supplementary values:	3	Not permitted to be reported under legislative arrangements in the jurisdiction

Collection and usage attributes

Guide for use:

CODE 1 Involuntary patient

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

CODE 2 Voluntary patient

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

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

Not permitted to be reported under legislative arrangements in the jurisdiction, is to be used for reporting to the National Minimum Data Set - Community mental health care, where applicable.

Data element attributes

Collection and usage attributes

Guide for use:

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

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

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

Collection methods:

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

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

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

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

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

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

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

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

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Mental health service contact date

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Mental health service contact—service contact date
Definition:	The date of each mental health service contact between a health service provider and patient/client.
Context:	Community-based mental health care and clinical settings
Object class:	Mental health service contact
Property:	Service contact date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

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

Relational attributes

Implementation in Data Set Specifications:	Community mental health care NMDS 2005-2006 NHIG, Superseded 07/12/2005 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Information specific to this data set:
Collection of the date of each service contact with health service providers allows a description or profile of service utilisation by a person or persons during an episode of care.

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

Mental health service contact duration

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Mental health service contact—mental health service contact duration
Definition:	The time from the start to finish of a service contact.
Context:	Specialised mental health services (Ambulatory mental health care services)
Object class:	Mental health service contact
Property:	Mental health service duration

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Mental health service contact—patient/client participation indicator

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Mental health service contact—patient / client participation indicator
Definition:	Indicates whether the patient / client has participated in a service contact.
Context:	Specialised mental health services (Ambulatory mental health care services)
Object class:	Mental health service contact
Property:	Patient / client participation indicator

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

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

- Code 1 is to be used for service contacts between a specialised mental health service provider and the patient / client in whose clinical record the service contact would normally warrant a dated entry, where the patient / client is participating.
- Code 2 is to be used for service contacts between a specialised mental health service provider and a third party(ies) where the patient / client, in whose clinical record the service contact would normally warrant a dated entry,

is not participating.

Relational attributes

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Mental health service contact—session type

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Mental health service contact—session type
Definition:	Whether a service contact is provided for one or more patient(s)/client(s).
Context:	Specialised mental health services (Ambulatory mental health care services)
Object class:	Mental health service contact
Property:	Session type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Individual session
2	Group session

Data element attributes

Collection and usage attributes

Guide for use:

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

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

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

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

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

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	State or Territory Government—mental health services grants to non-government organisations by non-health departments
Definition:	Grants made by state or territory departments outside the state or territory health portfolios directly to non-government organisations specifically for the provision of mental health activities or programs (other than staffed residential services).
Context:	Specialised mental health services
Object class:	State or Territory Government
Property:	Mental health services grants to non-government organisations from non-health departments

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

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

Relational attributes

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Information specific to this data set:
Do not include grants made by the state or territory health departments.

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

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

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

Method of birth

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Birth event—birth method
Definition:	The method of complete expulsion or extraction from its mother of a product of conception in a birth event.
Context:	Perinatal statistics
Object class:	Birth event
Property:	Birth method

Value domain attributes

Representational attributes

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

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Data element attributes

Collection and usage attributes

Guide for use:	In a vaginal breech with forceps to the after coming head, code as vaginal - forceps. In a vaginal breech that has been manually rotated, code as vaginal - non-instrumental. Where forceps/vacuum extraction are used to assist the extraction of the baby at caesarean section, code as caesarean section. Where a hysterotomy is performed to extract the baby, code as

caesarean section.

Collection methods: In the case of multiple births, method of birth should be recorded for each baby born.

Comments: Note: Code 3, which had a meaning in previous versions of the data standard is no longer used. As is good practice, the code will not be reused.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

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

Implementation in Data Set Specifications: Perinatal NMDS 2007-2008 NHIG, Standard 06/09/2006

Implementation start date: 01/07/2007

Method of use for principal drug of concern

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Client—method of drug use (principal drug of concern)
Definition:	The client's usual method of administering the principal drug of concern as stated by the client.
Context:	Alcohol and other drug treatment services
Object class:	Client
Property:	Method of drug use

Value domain attributes

Representational attributes

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

Permissible values:

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

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

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

Source and reference attributes

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

Relational attributes

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

Implementation in Data Set Specifications: Alcohol and other drug treatment services NMDS NHIG, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Microalbumin level—albumin/creatinine ratio (measured)

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Person—microalbumin level
Definition:	A person's microalbumin level in a spot test, 24 hour or timed collection.
Context:	Public health, health care and clinical settings.
Object class:	Person
Property:	Microalbumin level

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Collection methods:

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

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

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

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

The results considered elevated are

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

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

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

Supersedes Microalbumin / protein - measured, version 1, DE, NHDD, NHIMG, Superseded 01 / 03 / 2005

Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01 / 03 / 2005

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

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

Information specific to this data set:

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

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

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

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

Microalbumin level—micrograms per minute (measured)

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Person—microalbumin level
Definition:	A person's microalbumin level in a spot test, 24 hour or timed collection.
Context:	Public health, health care and clinical settings.
Object class:	Person
Property:	Microalbumin level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN].N
Maximum character length:	5
Supplementary values:	Value: 9999.9 — Meaning: Not stated/inadequately described
Unit of measure:	Microgram per minute (µg/min)
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Collection methods:	Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority. Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay. As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate. Test for albuminuria by measuring microalbumin in timed or first morning urine sample. The results considered elevated are

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

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references: Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Supersedes Microalbumin/protein - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

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

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

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

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

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

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

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

Microalbumin level—milligrams per 24 hour (measured)

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Person—microalbumin level
Definition:	A person's microalbumin level in a spot test, 24 hour or timed collection.
Context:	Public health, health care and clinical settings.
Object class:	Person
Property:	Microalbumin level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN].N
Maximum character length:	5
Supplementary values:	Value: 9999.9 — Meaning: Not stated/inadequately described
Unit of measure:	Milligram per 24-hour period (mg/24h)
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Collection methods:	Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority. Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay. As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate. Test for albuminuria by measuring microalbumin in timed or first morning urine sample. The results considered elevated are

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

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references: Supersedes Microalbumin/protein - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

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

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

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

Information specific to this data set:

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

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

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

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

Microalbumin level—milligrams per litre (measured)

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Person—microalbumin level
Definition:	A person's microalbumin level in a spot test, 24 hour or timed collection.
Context:	Public health, health care and clinical settings.
Object class:	Person
Property:	Microalbumin level

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNN].N
Maximum character length:	5
Supplementary values:	Value: 9999.9 — Meaning: Not stated/inadequately described
Unit of measure:	Milligram per litre (mg/L)
Unit of measure precision:	1

Data element attributes

Collection and usage attributes

Collection methods:

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

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

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

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

The results considered elevated are:

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

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references: Supersedes Microalbumin/protein - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

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

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

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

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

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

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

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

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

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Laboratory standard—upper limit of normal range for microalbumin
Definition:	Laboratory standard for the value of microalbumin that is the upper boundary of the normal reference range.
Context:	Public health, health care and clinical settings.
Object class:	Laboratory standard
Property:	Upper limit of normal range for microalbumin

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	Record the upper limit of the microalbumin normal reference range for the laboratory.
Collection methods:	Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay. Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority. As urinary albumin varies with posture and exercise it is

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

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references: Supersedes Microalbumin - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

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

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

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

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

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

If microalbuminuria is present:

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

If macroalbuminuria is present:

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

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

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Laboratory standard—upper limit of normal range for microalbumin
Definition:	Laboratory standard for the value of microalbumin that is the upper boundary of the normal reference range.
Context:	Public health, health care and clinical settings.
Object class:	Laboratory standard
Property:	Upper limit of normal range for microalbumin

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

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

hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references: Supersedes Microalbumin - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

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

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

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

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

If microalbuminuria is present:

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

If macroalbuminuria is present:

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

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

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Laboratory standard—upper limit of normal range for microalbumin
Definition:	Laboratory standard for the value of microalbumin that is the upper boundary of the normal reference range.
Context:	Public health, health care and clinical settings.
Object class:	Laboratory standard
Property:	Upper limit of normal range for microalbumin

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

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

hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references: Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Supersedes Microalbumin - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

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

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

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

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

If microalbuminuria is present:

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

If macroalbuminuria is present:

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

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

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Laboratory standard—upper limit of normal range for microalbumin
Definition:	Laboratory standard for the value of microalbumin that is the upper boundary of the normal reference range.
Context:	Public health, health care and clinical settings.
Object class:	Laboratory standard
Property:	Upper limit of normal range for microalbumin

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

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

hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references: Supersedes Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Supersedes Microalbumin - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

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

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

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

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

If microalbuminuria is present:

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

If macroalbuminuria is present:

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

Minutes of operating theatre time

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Admitted patient hospital stay—operating theatre time
Definition:	Total time spent by a patient in operating theatres during current episode of hospitalisation.
Context:	Admitted patient care
Object class:	Admitted patient hospital stay
Property:	Operating theatre time

Value domain attributes

Representational attributes

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

Collection and usage attributes

Collection methods:	Right justified, zero filled.

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Origin:	Health Data Standards Committee

Relational attributes

Related metadata references:	Supersedes Minutes of operating theatre time, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005

Mode of admission

Identifying and definitional attributes

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

Data element concept attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

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

Collection and usage attributes

Guide for use:

CODE 2 Statistical admission - episode type change

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

CODE 3 Other

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

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

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

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Mode of separation

Identifying and definitional attributes

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

Data element concept attributes

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

Value domain attributes

Representational attributes

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

Permissible values:

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

Collection and usage attributes

Guide for use:

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

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

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Mode of separation, version 3, DE, NHDD, NHIMG, Superseded 01 / 03 / 2005

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

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

Implementation in Data Set Specifications:

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

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

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

Implementation start date: 01 / 07 / 2005

Implementation end date: 30 / 06 / 2006

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

Implementation start date: 01 / 07 / 2006

Implementation end date: 30 / 06 / 2007

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

Implementation start date: 01 / 07 / 2007

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

Implementation start date: 01 / 07 / 2005

Implementation end date: 30 / 06 / 2006

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

Implementation start date: 01 / 07 / 2006

Implementation end date: 30 / 06 / 2007

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

Implementation start date: 01 / 07 / 2007

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

Implementation start date: 01 / 07 / 2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Morphology of cancer

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Person with cancer—morphology of cancer
Definition:	The morphology of a cancer refers to the histological classification of the cancer tissue (histopathological type) and a description of the course of development that a tumour is likely to take: benign or malignant (behaviour). The designation is based on a microscopic diagnosis of morphology by the pathologist (Esteban, Whelan, Laudico & Parkin 1995).
Object class:	Person with cancer
Property:	Morphology of cancer

Value domain attributes

Representational attributes

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

Collection and usage attributes

Guide for use:

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

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

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

0 Benign

1 Uncertain whether benign or malignant

- borderline malignancy
- low malignant potential

2 Carcinoma in situ

- intraepithelial
- non-infiltrating

- non-invasive

3 Malignant, primary site

6 Malignant, metastatic site

- malignant, secondary site

9 Malignant, uncertain whether primary or metastatic site

Source and reference attributes

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

Data element attributes

Collection and usage attributes

Collection methods:

Cancer registry use:

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

Hospital morbidity use:

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

Source and reference attributes

Origin:

World Health Organization

New South Wales Health Department

State and Territory Cancer Registries

Reference documents:

New South Wales Inpatient Statistics Collection Manual, 2000 / 2001

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

Relational attributes

Related metadata references: Supersedes Morphology of cancer, version 1, DE, NHDD, NHIMG, Superseded 01 / 03 / 2005

Implementation in Data Set Specifications:

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

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

Information specific to this data set:

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

Most valid basis of diagnosis of cancer

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Person with cancer—most valid basis of diagnosis of a cancer
Definition:	The basis of diagnosis of a cancer is the microscopic or non-microscopic or death certificate source of the diagnosis. The most valid basis of diagnosis is that accepted by the cancer registry as the most reliable diagnostic source of the death certificate, non-microscopic, and microscopic sources available.
Object class:	Person with cancer
Property:	Most valid basis of diagnosis of a cancer

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
0	Death certificate only: Information provided is from a death certificate
1	Clinical: Diagnosis made before death, but without any of the following (codes 2-7)
2	Clinical investigation: All diagnostic techniques, including x-ray, endoscopy, imaging, ultrasound, exploratory surgery (e.g. laparotomy), and autopsy, without a tissue diagnosis
4	Specific tumour markers: Including biochemical and/or immunological markers that are specific for a tumour site
5	Cytology: Examination of cells from a primary or secondary site, including fluids aspirated by endoscopy or needle; also includes the microscopic examination of peripheral blood and bone marrow aspirates
6	Histology of metastasis: Histological examination of tissue from a metastasis, including autopsy specimens

	7	Histology of a primary tumour: Histological examination of tissue from primary tumour, however obtained, including all cutting techniques and bone marrow biopsies; also includes autopsy specimens of primary tumour
	8	Histology: either unknown whether of primary or metastatic site, or not otherwise specified
Supplementary values:	9	Unknown.

Collection and usage attributes

Guide for use:

CODES 1 - 4

Non-microscopic.

CODES 5 - 8

Microscopic.

CODE 9

Other.

Comments:

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

Data element attributes

Collection and usage attributes

Guide for use:

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

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

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

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

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

a) the post-mortem report includes the post-mortem

histological diagnosis (in which case, one of the Histology codes should be recorded instead);

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

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

Source and reference attributes

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

Relational attributes

Related metadata references: Supersedes Most valid basis of diagnosis of cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Implementation in Data Set Specifications: Cancer (clinical) DSS NHIG, Superseded 07/12/2005

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

Information specific to this data set:
Knowledge of the basis of a diagnosis underlying a cancer code is one of the most important aids in assessing the reliability of cancer statistics.

Mother's original family name

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Person—mother's original family name
Definition:	The original family name of the person's mother as reported by the person.
Context:	May be used to confirm the identity of a person.
Object class:	Person
Property:	Mother's original family name

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

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

Relational attributes

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

Multi-disciplinary team status

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Non-admitted patient service event—multi-disciplinary team status
Definition:	A non-admitted multi-disciplinary team patient service event is one for which there is at most one appointment and the patient is assessed and/or treated by more than one medical practitioner, allied health practitioner and/or specialist nurse practitioner.
Context:	Hospital non-admitted patient care.
Object class:	Non-admitted patient service event
Property:	Multi-disciplinary team status

Value domain attributes

Representational attributes

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

Permissible values:

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

Data element attributes

Relational attributes

Related metadata references:	Supersedes Multi-disciplinary team status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Myocardial infarction (history)

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Person—myocardial infarction
Definition:	Whether the individual has had a myocardial infarction.
Context:	Public health, health care and clinical settings.
Object class:	Person
Property:	Myocardial infarction

Value domain attributes

Representational attributes

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

Permissible values:

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

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Collection methods:

Ask the individual if he/she has had a myocardial infarction. If so determine whether it was within or prior to the last 12 months (or both).Record if evidenced by ECG changes or plasma enzyme changes.

Alternatively obtain this information from appropriate documentation.

Source and reference attributes

Submitting organisation:	National diabetes data working group
Origin:	National Diabetes Outcomes Quality Review Initiative

(NDOQRIN) data dictionary.

Reference documents:

Long-term Results From the Diabetes and Insulin-Glucose Infusion in Acute Myocardial Infarction (DIGAMI) Study Circulation. 1999;99: 2626-2632.

Relational attributes

Related metadata references:

Supersedes Myocardial infarction - history, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Implementation in Data Set Specifications:

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

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

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

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

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

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

Name context flag

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Person (name)—name conditional use flag
Definition:	An indicator of specific conditions that may be applied to an individual's name.
Object class:	Person
Property:	Name conditional use flag

Value domain attributes

Representational attributes

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

Permissible values:

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

Data element attributes

Collection and usage attributes

Guide for use:

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

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

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

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

policy should provide guidance to the use of this code.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	National Health Data Committee National Community Services Data Committee Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia
Reference documents:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references:	Supersedes Person (name)—name context flag, code N NHIG, Superseded 04/05/2005, NCSIMG, Superseded 25/08/2005
Implementation in Data Set Specifications:	Health care client identification DSS NHIG, Standard 04/05/2005 Health care provider identification DSS NHIG, Superseded 04/07/2007 Health care provider identification DSS NHIG, Standard 04/07/2007

Name suffix

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Person (name)—name suffix
Definition:	Additional term following a person's name used to identify a person when addressing them by name, whether by mail, by phone, or in person.
Object class:	Person
Property:	Name suffix

Value domain attributes

Representational attributes

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

Collection and usage attributes

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

Source and reference attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Person (name)—name suffix, text [A(12)] NHIG, Superseded 04/05/2005, NCSIMG, Superseded 25/08/2005
Implementation in Data Set Specifications:	Health care client identification DSS NHIG, Standard 04/05/2005 Health care provider identification DSS NHIG, Superseded 04/07/2007 Health care provider identification DSS NHIG, Standard 04/07/2007

Name suffix sequence number

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Person (name)—name suffix sequence number
Definition:	The numeric order of any additional terms used at the conclusion of a name.
Object class:	Person
Property:	Name suffix sequence number

Value domain attributes

Representational attributes

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

Permissible values:

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

Data element attributes

Collection and usage attributes

Collection methods:

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

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

Source and reference attributes

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

Relational attributes

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

Name title

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Person (name)—name title
Definition:	An honorific form of address, commencing a name, used when addressing a person by name, whether by mail, by phone, or in person.
Object class:	Person
Property:	Name title

Value domain attributes

Representational attributes

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

Collection and usage attributes

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

Source and reference attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation: Standards Australia

Origin: National Health Data Committee

National Community Services Data Committee

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

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

Relational attributes

Related metadata references: Supersedes Person (name)—name title, text [A(12)] NHIG, Superseded 04/05/2005, NCSIMG, Superseded 25/08/2005

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

Information specific to this data set:
For the purpose of positive identification of a person, each name title should be associated with a Name title sequence number.

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

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

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

Information specific to this data set:
For the purpose of positive identification of a person, each name title should be associated with a Name title sequence number.

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

Name title sequence number

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Person (name)—name title sequence number
Definition:	The numeric order of an honorific form of address commencing a person's name.
Object class:	Person
Property:	Name title sequence number

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Value domain attributes

Representational attributes

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

Permissible values:

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

Data element attributes

Collection and usage attributes

Collection methods:

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

Example: Professor Sir John Markham

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

Source and reference attributes

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

Relational attributes

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

Name type

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Person (name)—name type
Definition:	A classification that enables differentiation between recorded names for a person.
Object class:	Person
Property:	Name type

Value domain attributes

Representational attributes

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

Permissible values:

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

Data element attributes

Collection and usage attributes

Guide for use:

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

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

Field value definitions for Person name type codes are:

Code 1 - Preferred name is the name by which the person chooses to be identified.
There should only be one preferred name recorded for a person.

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

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

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

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

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Person (name)—name type, code A NHIG, Superseded 04 / 05 / 2005
Implementation in Data Set Specifications:	Health care client identification DSS NHIG, Standard 04 / 05 / 2005 Health care provider identification DSS NHIG, Superseded 04 / 07 / 2007 Health care provider identification DSS NHIG, Standard 04 / 07 / 2007

Name type (service provider organisation)

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Service provider organisation (name)—name type
Definition:	A classification that enables differentiation between recorded names for an establishment, agency or organisation.
Context:	Administrative purposes and organisation identification
Object class:	Service provider organisation
Property:	Name type

Value domain attributes

Representational attributes

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

Permissible values:

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

Supplementary values:

9	Unknown

Collection and usage attributes

Guide for use:

CODE 1 Organisation unit/section/division

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

CODE 2 Service location name

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

CODE 3 Business name

Business name used only for trading purposes.

CODE 4 Locally used name

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

CODE 5 Abbreviated name

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

CODE 6 Enterprise name

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

CODE 8 Other

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

CODE 9 Unknown

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

Data element attributes

Collection and usage attributes

Guide for use:

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

Relational attributes

Implementation in Data Set Specifications:

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

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

Narrative description of injury event

Identifying and definitional attributes

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

Data element concept attributes

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

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

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

Relational attributes

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

Implementation in Data Set Specifications: Injury surveillance DSS NHIG, Standard 03/05/2006

Injury surveillance NMDS NHIG, Superseded 03/05/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Injury surveillance NMDS NHIG, Superseded 07/12/2005

National standards for mental health services review status

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Specialised mental health service unit—implementation of National standards for mental health services status
Definition:	The extent of progress made by a specialised mental health service unit in implementing the National Standards for Mental Health Services by or at 30 June.
Context:	Specialised mental health services.
Object class:	Specialised mental health service unit
Property:	Implementation of National standards for mental health services status

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	The service unit had been reviewed by an external accreditation agency and was judged to have met the National standards
2	The service unit had been reviewed by an external accreditation agency and was judged to have met some but not all of the National standards
3	The service unit was in the process of being reviewed by an external accreditation agency but the outcomes were not known
4	The service unit was booked for review by an external accreditation agency and was engaged in self-assessment preparation prior to the formal external review
5	The service unit was engaged in self-assessment in relation to the National Standards but did not have a contractual arrangement with an

	external accreditation agency for review
6	The service unit had not commenced the preparations for review by an external accreditation agency but this was intended to be undertaken in the future
7	It had not been resolved whether the service unit would undertake review by an external accreditation agency under the National standards
8	The National standards are not applicable to this service unit

Collection and usage attributes

Guide for use:

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

This code should only be used for:

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

Data element attributes

Collection and usage attributes

Collection methods:

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

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

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

Relational attributes

Implementation in Data Set Specifications:

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

Implementation start date: 01 / 07 / 2005

Implementation end date: 30 / 06 / 2006

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

Implementation start date: 01 / 07 / 2006

Implementation end date: 30 / 06 / 2007

Mental health establishments NMDS 2007-2008 NHIG,

Standard 23/10/2006

Implementation start date: 01/07/2007

Information specific to this data set:
Obligation condition: reporting of this data element is optional for non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding.

Nature of main injury (non-admitted patient)

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Injury event—nature of main injury
Definition:	The nature of the injury chiefly responsible for the attendance of the non-admitted patient at the health care facility.
Context:	Injury surveillance
Object class:	Injury event
Property:	Nature of main injury

Value domain attributes

Representational attributes

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

Permissible values:

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

14.2	Foreign body in ear canal
14.3	Foreign body in nose
14.4	Foreign body in respiratory tract (excludes foreign body in nose code 14.3)
14.5	Foreign body in alimentary tract
14.6	Foreign body in genitourinary tract
14.7	Foreign body in soft tissue
14.9	Foreign body, other / unspecified
20	Intracranial injury (includes concussion)
21	Dental injury (includes fractured tooth)
22	Drowning, immersion
23	Asphyxia or other threat to breathing (excludes drowning immersion code 22)
24	Electrical injury
25	Poisoning, toxic effect (excludes effect of venom, or any insect bite code 26)
26	Effect of venom, or any insect bite
27	Other specified nature of injury
28	Injury of unspecified nature
29	Multiple injuries of more than one 'nature'
30	No injury detected

Data element attributes

Collection and usage attributes

Guide for use:

If the full ICD-10-AM (3rd edition) code is used to code the injury, this metadata item is not required (see metadata items principal diagnosis and additional diagnosis) When coding to the full ICD-10-AM (3rd edition) code is not possible, use this metadata item with the items external cause of injury-non admitted patient, external cause of injury-human intent and bodily location of main injury.

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

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

Comments:

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

This metadata item is related to the ICD-10-AM injury and poisoning classification. However, coding to the full ICD-10-AM injury and poisoning classification (see metadata item principal diagnosis) is not available in most settings where basic injury surveillance is undertaken. This item, in combination with the metadata item Bodily location of main injury, is a practicable alternative. Data coded to the full ICD-10-AM codes can be aggregated to match this item, facilitating data comparison. Further information on the national injury surveillance program can be obtained from the National Injury Surveillance Unit, Flinders University, Adelaide.

Source and reference attributes

Submitting organisation:

National Injury Surveillance Unit, Flinders University, Adelaide

National Data Standards for Injury Surveillance Advisory Group

Reference documents:

International Classification of Diseases - Tenth Revision - Australian Modification (3rd Edition 2002) National Centre for Classification in Health, Sydney

Relational attributes

Related metadata references:

Supersedes Nature of main injury - non-admitted patient, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Implementation in Data Set Specifications:

Injury surveillance DSS NHIG, Standard 03/05/2006

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

Injury surveillance NMDS NHIG, Superseded 03/05/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Injury surveillance NMDS NHIG, Superseded 07/12/2005

Neonatal morbidity

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Admitted patient (neonate)—neonatal morbidity, code (ICD-10-AM 5th edn) ANN{.N[N]}
METeOR identifier:	333806
Registration status:	NHIG, Standard 07/12/2005
Definition:	Conditions or diseases of the baby, as represented by an ICD-10-AM code.

Data element concept attributes

Data element concept:	Admitted patient (neonate)—neonatal morbidity
Definition:	Conditions or diseases of the baby.
Context:	Perinatal statistics
Object class:	Admitted patient
Property:	Neonatal morbidity

Value domain attributes

Representational attributes

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

Collection and usage attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Admitted patient (neonate)—neonatal morbidity, code (ICD-10-AM 4th edn) ANN{.N[N]} NHIG, Superseded 07/12/2005

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

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Establishment—net capital expenditure (accrual accounting) (buildings and building services)
Definition:	Net capital expenditure on buildings and building services (including plant).
Context:	Health expenditure: Net capital expenditure is a significant, though variable, element of total health establishment expenditure. Just as recurrent expenditure is broken down into a number of major categories to enable a proper analysis of health expenditure at the national level, so capital expenditure is to be broken down into a number of major categories. Capital expenditure in the context of hospitals and closely related establishments is a relatively undeveloped area. Nevertheless, there is a considerable interest in health establishment capital expenditure data at the national level from many different potential users.
Object class:	Establishment
Property:	Net capital expenditure

Collection and usage attributes

Guide for use:	This definition is for use where the accrual method of accounting has been adopted. Buildings and building services (including plant): An edifice that has a service potential constructed, acquired or held by a financial lease for the specific purposes of the entity. Includes hospitals, residential aged care services and other buildings used for providing the service. Includes expenditure on installation, alteration and improvement of fixtures, facilities and equipment that are an integral part of the building and that contribute to the primary function of a building to either directly or indirectly support the delivery of products and services. Excludes repair and replacement of worn-out or damaged fixtures (to be treated as maintenance).

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	Round to nearest dollar.

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005
Implementation in Data Set Specifications:	Public hospital establishments NMDS NHIG, Superseded 21/03/2006 *Implementation start date:* 01/07/2005 *Implementation end date:* 30/06/2006 Public hospital establishments NMDS NHIG, Superseded 23/10/2006 *Implementation start date:* 01/07/2006 *Implementation end date:* 30/06/2007 Public hospital establishments NMDS 2007-2008 NHIG, Standard 23/10/2006 *Implementation start date:* 01/07/2007

Net capital expenditure (accrual accounting)—constructions

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Establishment—net capital expenditure (accrual accounting) (constructions)
Definition:	Net capital expenditure on constructions (other than buildings).
Context:	Health expenditure: Net capital expenditure is a significant, though variable, element of total health establishment expenditure. Just as recurrent expenditure is broken down into a number of major categories to enable a proper analysis of health expenditure at the national level, so capital expenditure is to be broken down into a number of major categories. Capital expenditure in the context of hospitals and closely related establishments is a relatively undeveloped area. Nevertheless, there is a considerable interest in health establishment capital expenditure data at the national level from many different potential users.
Object class:	Establishment
Property:	Net capital expenditure

Collection and usage attributes

Guide for use:	This definition is for use where the accrual method of accounting has been adopted. Constructions (other than buildings): Expenditure on construction, major alterations and additions to fixed assets other than buildings such as car parks, roads, bridges, storm water channels, dams, drainage and sanitation systems, sporting facilities, gas, water and electricity mains, communication systems, landscaping and grounds reticulation systems. Includes expenditure on land reclamation, land clearance and raising or levelling of building sites.

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]

Maximum character length: 9

Unit of measure: Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use: Round to nearest dollar.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

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

Implementation in Data Set Specifications: Public hospital establishments NMDS NHIG, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 NHIG, Standard 23/10/2006

Implementation start date: 01/07/2007

Net capital expenditure (accrual accounting)—equipment

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Establishment—net capital expenditure (accrual accounting) (equipment)
Definition:	Net capital expenditure on equipment.
Context:	Health expenditure: Net capital expenditure is a significant, though variable, element of total health establishment expenditure. Just as recurrent expenditure is broken down into a number of major categories to enable a proper analysis of health expenditure at the national level, so capital expenditure is to be broken down into a number of major categories. Capital expenditure in the context of hospitals and closely related establishments is a relatively undeveloped area. Nevertheless, there is a considerable interest in health establishment capital expenditure data at the national level from many different potential users.
Object class:	Establishment
Property:	Net capital expenditure

Collection and usage attributes

Guide for use:	This definition is for use where the accrual method of accounting has been adopted. Equipment: An asset, not an integral part of any building or construction, used by an entity to support the delivery of products and services. Items may be fixed or moveable.

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use: Round to nearest dollar.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

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

Implementation in Data Set Specifications: Public hospital establishments NMDS NHIG, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 NHIG, Standard 23/10/2006

Implementation start date: 01/07/2007

Net capital expenditure (accrual accounting)—information technology

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Establishment—net capital expenditure (accrual accounting) (information technology)
Definition:	Net capital expenditure on information technology.
Context:	Health expenditure: Net capital expenditure is a significant, though variable, element of total health establishment expenditure. Just as recurrent expenditure is broken down into a number of major categories to enable a proper analysis of health expenditure at the national level, so capital expenditure is to be broken down into a number of major categories. Capital expenditure in the context of hospitals and closely related establishments is a relatively undeveloped area. Nevertheless, there is a considerable interest in health establishment capital expenditure data at the national level from many different potential users.
Object class:	Establishment
Property:	Net capital expenditure

Collection and usage attributes

Guide for use:	This definition is for use where the accrual method of accounting has been adopted. Information technology: Computer installations and equipment such as mainframe and mini-computers, personal computer networks and related hardware.

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use: Round to nearest dollar.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

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

Implementation in Data Set Specifications: Public hospital establishments NMDS NHIG, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 NHIG, Standard 23/10/2006

Implementation start date: 01/07/2007

Net capital expenditure (accrual accounting)—intangible assets

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Establishment—net capital expenditure (accrual accounting) (intangible assets)
Definition:	Net capital expenditure on intangible assets.
Context:	Health expenditure: Net capital expenditure is a significant, though variable, element of total health establishment expenditure. Just as recurrent expenditure is broken down into a number of major categories to enable a proper analysis of health expenditure at the national level, so capital expenditure is to be broken down into a number of major categories. Capital expenditure in the context of hospitals and closely related establishments is a relatively undeveloped area. Nevertheless, there is a considerable interest in health establishment capital expenditure data at the national level from many different potential users.
Object class:	Establishment
Property:	Net capital expenditure

Collection and usage attributes

Guide for use:	This definition is for use where the accrual method of accounting has been adopted. Intangible: An asset which does not have physical substance, such as copyright, design, patent, trademark, franchise or licence.

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use: Round to nearest dollar.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

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

Implementation in Data Set Specifications: Public hospital establishments NMDS NHIG, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 NHIG, Standard 23/10/2006

Implementation start date: 01/07/2007

Net capital expenditure (accrual accounting)—land

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Establishment—net capital expenditure (accrual accounting) (land)
Definition:	Net capital expenditure on land.
Context:	Health expenditure: Net capital expenditure is a significant, though variable, element of total health establishment expenditure. Just as recurrent expenditure is broken down into a number of major categories to enable a proper analysis of health expenditure at the national level, so capital expenditure is to be broken down into a number of major categories. Capital expenditure in the context of hospitals and closely related establishments is a relatively undeveloped area. Nevertheless, there is a considerable interest in health establishment capital expenditure data at the national level from many different potential users.
Object class:	Establishment
Property:	Net capital expenditure

Collection and usage attributes

Guide for use:	This definition is for use where the accrual method of accounting has been adopted. Land: A solid section of the earth's surface which is held by the entity under a certificate of title or reserve, leased in by the entity or allocated to the entity by another agency.

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use: Round to nearest dollar.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

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

Implementation in Data Set Specifications: Public hospital establishments NMDS NHIG, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 NHIG, Standard 23/10/2006

Implementation start date: 01/07/2007

Net capital expenditure (accrual accounting)—major medical equipment

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Establishment—net capital expenditure (accrual accounting) (major medical equipment)
Definition:	Net capital expenditure on major medical equipment.
Context:	Health expenditure: Net capital expenditure is a significant, though variable, element of total health establishment expenditure. Just as recurrent expenditure is broken down into a number of major categories to enable a proper analysis of health expenditure at the national level, so capital expenditure is to be broken down into a number of major categories. Capital expenditure in the context of hospitals and closely related establishments is a relatively undeveloped area. Nevertheless, there is a considerable interest in health establishment capital expenditure data at the national level from many different potential users.
Object class:	Establishment
Property:	Net capital expenditure

Collection and usage attributes

Guide for use:	This definition is for use where the accrual method of accounting has been adopted. Major medical equipment: Major items of medical equipment such as medical imaging (computed tomography (CT) scanners, magnetic resonance imaging (MRI), radiology), **intensive care unit** (ICU) monitors and transplant equipment.

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use: Round to nearest dollar.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

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

Implementation in Data Set Specifications: Public hospital establishments NMDS NHIG, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 NHIG, Standard 23/10/2006

Implementation start date: 01/07/2007

Net capital expenditure (accrual accounting)—other equipment

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Establishment—net capital expenditure (accrual accounting) (other equipment)
Definition:	Net capital expenditure on other equipment.
Context:	Health expenditure: Net capital expenditure is a significant, though variable, element of total health establishment expenditure. Just as recurrent expenditure is broken down into a number of major categories to enable a proper analysis of health expenditure at the national level, so capital expenditure is to be broken down into a number of major categories. Capital expenditure in the context of hospitals and closely related establishments is a relatively undeveloped area. Nevertheless, there is a considerable interest in health establishment capital expenditure data at the national level from many different potential users.
Object class:	Establishment
Property:	Net capital expenditure

Collection and usage attributes

Guide for use:	This definition is for use where the accrual method of accounting has been adopted. Other equipment: Includes machinery and equipment not elsewhere classified, such as furniture, art objects, professional instruments and containers.

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use: Round to nearest dollar.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

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

Implementation in Data Set Specifications: Public hospital establishments NMDS NHIG, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 NHIG, Standard 23/10/2006

Implementation start date: 01/07/2007

Net capital expenditure (accrual accounting)—transport

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Establishment—net capital expenditure (accrual accounting) (transport)
Definition:	Net capital expenditure on transport.
Context:	Health expenditure: Net capital expenditure is a significant, though variable, element of total health establishment expenditure. Just as recurrent expenditure is broken down into a number of major categories to enable a proper analysis of health expenditure at the national level, so capital expenditure is to be broken down into a number of major categories. Capital expenditure in the context of hospitals and closely related establishments is a relatively undeveloped area. Nevertheless, there is a considerable interest in health establishment capital expenditure data at the national level from many different potential users.
Object class:	Establishment
Property:	Net capital expenditure

Collection and usage attributes

Guide for use:	This definition is for use where the accrual method of accounting has been adopted. Transport: Expenditure on vehicles or equipment used for transport such as motor vehicles, aircraft, ships, railway, tramway rolling stock, and attachments (such as trailers). Includes major parts such as engines.

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use: Round to nearest dollar.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

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

Implementation in Data Set Specifications: Public hospital establishments NMDS NHIG, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 NHIG, Standard 23/10/2006

Implementation start date: 01/07/2007

New/repeat status

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Non-admitted patient service event—new / repeat service event status
Definition:	A new non-admitted patient service event is one for a problem not previously addressed at the same clinical service. All other non-admitted patient service events are repeat service events.
Context:	Hospital non-admitted patient care.
Object class:	Non-admitted patient service event
Property:	New / repeat service event status

Value domain attributes

Representational attributes

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

Permissible values:

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

Collection and usage attributes

Guide for use:

CODE 1 New non-admitted patient service event:

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

CODE 2 Repeat non-admitted patient service event:

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

Data element attributes

Relational attributes

Related metadata references:	Supersedes New / repeat status, version 1, DE, NHDD, NHIMG, Superseded 01 / 03 / 2005

Non-Australian state/province (person)

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Person (address)—non-Australian state / province
Definition:	The designation applied to an internal, political or geographic division of a country other than Australia that is officially recognised by that country that is associated with the address of a person.
Object class:	Person
Property:	Non-Australian state / province

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

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

Relational attributes

Implementation in Data Set Specifications:

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

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

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

Information specific to this data set:
When used for identification purposes record this data element as part of an address.

Non-Australian state/province (service provider organisation)

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Service provider organisation (address)—non-Australian state / province
Definition:	The designation applied to an internal, political or geographic division of a country other than Australia that is officially recognised by that country that is associated with the address of an establishment.
Object class:	Service provider organisation
Property:	Non-Australian state / province

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

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

Relational attributes

Implementation in Data Set Specifications:

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

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

Information specific to this data set:
When used for identification purposes record this data element as part of an address.

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

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient emergency department service episode—triage category, code N
Synonymous names:	Triage category
METeOR identifier:	270078
Registration status:	NHIG, 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 attributes

Data element concept:	Non-admitted patient emergency department service episode—triage category
Definition:	The urgency of the patient's need for medical and nursing care.
Context:	Emergency department care: Required to provide data for analysis of emergency department processes.
Object class:	Non-admitted patient emergency department service episode
Property:	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

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

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

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

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Number of available beds for admitted patients

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Establishment—number of available beds for admitted patients / residents
Definition:	The number of beds which are immediately available for use by an admitted patient or **resident** within the establishment. A bed is immediately available for use if it is located in a suitable place for care with nursing and auxiliary staff available within a reasonable period.
Context:	Necessary to provide an indicator of the availability and type of service for an establishment.
Object class:	Establishment
Property:	Number of available beds for admitted patients / residents

Collection and usage attributes

Guide for use:	Inclusions: both occupied and unoccupied beds are included. For residential aged care services, the number of approved beds includes beds approved for respite care. Exclusions: surgical tables, recovery trolleys, delivery beds, cots for normal neonates, emergency stretchers / beds not normally authorised or funded and beds designated for same-day non-admitted patient care are excluded. Beds in wards which were closed for any reason (except weekend closures for beds / wards staffed and available on weekdays only) are also excluded.

Value domain attributes

Representational attributes

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

Collection and usage attributes

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

Data element attributes

Collection and usage attributes

Guide for use: The average bed is to be calculated from monthly figures.

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

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

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

Implementation in Data Set Specifications: Community mental health establishments NMDS 2004-2005 NHIG, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

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

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

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Public hospital establishments NMDS 2007-2008 NHIG, Standard 23/10/2006

Implementation start date: 01/07/2007

Number of caesarean sections

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Female—number of caesarean sections
Definition:	The number of caesarean sections performed on the woman.
Context:	Perinatal statistics
Object class:	Female
Property:	Number of previous caesarean sections

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
99	Not stated/Inadequately described

Proposed unit of measure: Caesarean sections

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Number of contacts—psychiatric outpatient clinic/day program

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Patient—number of psychiatric outpatient clinic / day program attendances
Definition:	Number of days that a patient attended a psychiatric outpatient clinic or a day program.
Context:	Mental health statistics
Object class:	Patient
Property:	Number of psychiatric outpatient clinic / day program attendances

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

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

contact dates, total N[NN] with the expectation that agencies will make their best efforts to report against the new version of this metadata item (Person—number of service contact dates, total N[NN]) from 1 July 1999.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

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

Number of days in special/neonatal intensive care

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Episode of admitted patient care—length of stay (special / neonatal intensive care)
Definition:	Number of days spent by a neonate in a special care or neonatal intensive care nursery (in the hospital of birth).
Context:	Admitted patient care and perinatal statistics
Object class:	Episode of admitted patient care
Property:	Length of stay

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

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

hospital. These NICN also provide consultative services to other hospitals.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Number of days in special / neonatal intensive care, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005

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

Identifying and definitional attributes

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

Data element concept attributes

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

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

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

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

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

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Number of days of hospital-in-the-home care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Number of episodes of residential care

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Episode of residential care—number of episodes of residential care
Definition:	The number of episodes of completed residential care occurring during the reference period. This includes both formal and statistical episodes of residential care.
Object class:	Episode of residential care
Property:	Number of episodes of residential care

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	The sum of the number of episodes of residential care where the Episode of residential care end date has a value: • Equal to or greater than the beginning of the reference period (01 July each year); and • Less than or equal to the end of the reference period (30 June each year at midnight).
Collection methods:	To be reported for all specialised residential mental health care services, including non-government residential mental health care services and

Relational attributes

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Number of group sessions

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Establishment—number of group sessions
Definition:	The number of groups of patients receiving services. Each group is to be counted once, irrespective of the size of the group or the number of staff providing services.
Context:	The resources required to provide services to groups of patients/clients are different from those required to provide services to an equivalent number of individuals. Hence services to groups of non-admitted patients or clients should be counted separately from services to individuals.
Object class:	Establishment
Property:	Number of group sessions

Source and reference attributes

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

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	A group is defined as two or more patients receiving the same services at the same time from the same hospital staff at the same clinics. The following guides for use apply: • a group session is counted only for two or more patients attending in the capacity of patients in their own right, even if other non-patient persons are present for the service.

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

Collection methods: Where a patient receives multidisciplinary care within one booked clinic appointment as part of a group, one group session shall be recorded, regardless of the number of providers involved. For example, if a group session is jointly delivered by a physiotherapist and an occupational therapist, one group session is counted for the patients attending that session.

Source and reference attributes

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

Relational attributes

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

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

Implementation start date: 01/07/2007

Number of leave periods

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Episode of admitted patient care—number of leave periods
Definition:	Number of **leave period**s in a hospital stay (excluding one-day leave periods for admitted patients). Leave period is a temporary absence from hospital, with medical approval for a period no greater than seven consecutive days.
Object class:	Episode of admitted patient care
Property:	Number of leave periods

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Origin:	National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Number of leave periods, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005

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

Number of occasions of service

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Establishment—number of occasions of service
Definition:	The number of occasions of examination, consultation, treatment or other service provided to a patient.
Context:	Occasions of service are required as a measure of non-admitted patient service provision.
Object class:	Establishment
Property:	Number of occasions of service

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use: The following guides for use apply:

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

- An occasion of service is counted for staff attending clinics of public hospitals only if they are attending as patients in their own right. Staff education and training is excluded.
- Patients attending for treatment at a dialysis or a chemotherapy clinic are receiving individual services. Patients attending education sessions at chemotherapy or dialysis clinics are counted as group sessions, if two or more people receiving the same services at the same time.

Collection methods:

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

Source and reference attributes

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

Relational attributes

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

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

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

Implementation start date: 01/07/2007

Number of qualified days for newborns

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Episode of admitted patient care (newborn)—number of qualified days
Definition:	The number of qualified newborn days occurring within a newborn episode of care.
Context:	Admitted patient care - newborn episodes of care only.
Object class:	Episode of admitted patient care
Property:	Number of qualified days

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

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

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

The length of stay for a newborn episode of care is equal to the

sum of the qualified and unqualified days.

Relational attributes

Related metadata references:

Supersedes Number of qualified days for newborns, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005

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

Is used in the formation of Establishment—number of patient days, total N[N(7)] NHIG, Standard 01/03/2005

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Number of service contact dates

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Person—number of service contact dates
Definition:	The number of dates where a service contact was recorded for the patient/client.
Context:	Community-based mental health care
Object class:	Person
Property:	Number of service contact dates

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation:	National Mental Health Information Strategy Committee

Relational attributes

Related metadata references:	Is formed using Service contact—service contact date, DDMMYYYY NHIG, Standard 01/03/2005 Supersedes Number of service contact dates, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005

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

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Episode of treatment for alcohol and other drugs—number of service contacts
Definition:	Number of service contacts recorded between a client and the service provider within a treatment episode for the purpose of providing alcohol and other drug treatment.
Context:	Alcohol and other drug treatment services
Object class:	Episode of treatment for alcohol and other drugs
Property:	Number of service contacts

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

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

Comments: This metadata item provides a measure of the frequency of client contact and service utilisation within a treatment episode.

Source and reference attributes

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

Relational attributes

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

Number of service events (non-admitted patient)

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Establishment—number of non-admitted patient service events
Definition:	The number of service events provided to non-admitted patients in the reference period, for each of the clinical service types in the hospital.
Context:	Hospital non-admitted patient care - public patients only
Object class:	Establishment
Property:	Number of non-admitted patient service events

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

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

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

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

hospital code N{N}

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

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Non-admitted patient service event count, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Nursing diagnosis—other

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Episode of care—nursing diagnosis
Definition:	Nursing diagnosis is a clinical judgement about individual, family or community responses to actual or potential health problems/life processes. Nursing diagnoses provide the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable.
Context:	Enables analysis of information by diagnostic variables especially in relation to the development of outcome information, the goal of care and the nursing intervention. This metadata item and the metadata item nursing intervention have shown to be more predictive of resource use than client's functional status or medical diagnosis.
Object class:	Episode of care
Property:	Nursing diagnosis

Value domain attributes

Representational attributes

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

Collection and usage attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

Up to seven nursing diagnoses may be nominated, according to the following:

1. Nursing diagnosis most related to the principal reason for admission (one only)

2-6. Other nursing diagnoses or relevance to the current episode.

Collection methods:

In considering how nursing diagnosis could be implemented, agencies may opt to introduce systems transparent to the clinician if there is confidence that a direct and reliable transfer to NANDA codes can be made from information already in place.

Agencies implementing new information systems should consider the extent to which these can facilitate practice and at the same time lighten the burden of documentation. Direct incorporation of the codeset or automated mapping to it when the information is at a more detailed level are equally valid and viable options.

Comments:

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

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Relational attributes

Related metadata references:

Supersedes Nursing diagnosis, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005

Nursing diagnosis—principal

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Episode of care—nursing diagnosis
Definition:	Nursing diagnosis is a clinical judgement about individual, family or community responses to actual or potential health problems/life processes. Nursing diagnoses provide the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable.
Context:	Enables analysis of information by diagnostic variables especially in relation to the development of outcome information, the goal of care and the nursing intervention. This metadata item and the metadata item nursing intervention have shown to be more predictive of resource use than client's functional status or medical diagnosis.
Object class:	Episode of care
Property:	Nursing diagnosis

Value domain attributes

Representational attributes

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

Collection and usage attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

Up to seven nursing diagnoses may be nominated, according to the following:

1. Nursing diagnosis most related to the principal reason for admission (one only)

2-6. Other nursing diagnoses of relevance to the current episode.

Collection methods:

In considering how nursing diagnosis could be implemented, agencies may opt to introduce systems transparent to the clinician if there is confidence that a direct and reliable transfer to NANDA codes can be made from information already in place.

Agencies implementing new information systems should consider the extent to which these can facilitate practice and at the same time lighten the burden of documentation. Direct incorporation of the code set or automated mapping to it when the information is at a more detailed level are equally valid and viable options.

Comments:

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

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Relational attributes

Related metadata references:

Supersedes Nursing diagnosis, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005

Nursing interventions

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Community nursing service episode—nursing intervention
Definition:	The nursing action intended to relieve or alter a person's responses to actual or potential health problems.
Object class:	Community nursing service episode
Property:	Nursing intervention

Value domain attributes

Representational attributes

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

Permissible values:

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

Collection and usage attributes

Guide for use:

The following definitions are to assist in coding:

CODE 1 Coordination and collaboration of care

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

recognised by specific funding (see Code 8).

CODE 2 Supporting information carers

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

CODE 3 General nursing care

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

CODE 4 Technical nursing treatment or procedure

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

CODE 5 Counselling and emotional support

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

CODE 6 Teaching / education

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

CODE 7 Monitoring and surveillance

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

CODE 8 Formal case management

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

CODE 9 Service needs assessment only

This code is for assessment of the person when this is the only activity carried out and no further nursing care is given; for example, assessment for ongoing care and / or inappropriate referrals. Selection of this option means that no other intervention may be nominated. Thus, if an assessment for the domiciliary care benefit is the reason for a visit, but other

interventions such as, counselling and support; coordination / collaboration of care are carried out, then the assessment only is not an appropriate code.

Data element attributes

Collection and usage attributes

Guide for use:

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

Collection methods:

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

Comments:

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

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

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

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

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

Source and reference attributes

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

Relational attributes

Related metadata references:	Supersedes Nursing interventions, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005

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

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Establishment (residential aged care service)—number of occasions of service
Definition:	The number of occasions of service provided by a residential aged care service.
Context:	Non-admitted patient care
Object class:	Establishment
Property:	Number of occasions of service

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation:	National minimum data set working parties

Relational attributes

Related metadata references:	Supersedes Type of non-admitted patient care (residential aged care services), version 1, DE, NHDD, NHIMG, Superseded

Occasions of service (residential aged care services)—outpatient

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Establishment (residential aged care service)—number of occasions of service
Definition:	The number of occasions of service provided by a residential aged care service.
Context:	Non-admitted patient care
Object class:	Establishment
Property:	Number of occasions of service

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

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

Oestrogen receptor assay status

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Person with cancer—oestrogen receptor assay results
Definition:	The results of oestrogen receptor assay at the time of diagnosis of the primary breast tumour.
Context:	Collected for breast cancers.
Object class:	Person with cancer
Property:	Oestrogen receptor assay result

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Comments:

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

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

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

Source and reference attributes

Origin:	Royal College of Pathologists of Australasia Australian Cancer Network Commission on Cancer American College of Surgeons
Reference documents:	Royal College of Pathologists of Australasia Manual of Use and Interpretation of Pathology Tests: Third Edition Sydney (2001) Australian Cancer Network Working Party The pathology reporting of breast cancer. A guide for pathologists, surgeons and radiologists Second Edition Sydney (2001) Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

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

Onset of labour

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Birth event—labour onset type
Definition:	The manner in which labour started in a birth event.
Context:	Perinatal care
Object class:	Birth event
Property:	Labour onset type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Spontaneous
2	Induced
3	No labour

Supplementary values:

4	Not stated

Collection and usage attributes

Guide for use:

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

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

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

Data element attributes

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Onset of labour, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005

Implementation in Data Set Specifications:

Perinatal NMDS NHIG, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS NHIG, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Information specific to this data set:
How labour commenced is closely associated with method of birth and maternal and neonatal morbidity. Induction rates vary for maternal risk factors and obstetric complications and are important indicators of obstetric intervention.

Ophthalmological assessment—outcome (left retina)

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Person—ophthalmological assessment outcome
Definition:	The result of an ophthalmological assessment.
Context:	Public health, health care and clinical settings.
Object class:	Person
Property:	Ophthalmological assessment outcome

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Normal
	2	Diabetes abnormality
	3	Non-diabetes abnormality
	4	Not visualised
Supplementary values:	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

This is a repeating record of both eyes.

1st field - Right retina

2nd field - Left retina

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

Example:

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

Only the result of an assessment carried out in the last 12

months should be recorded.

Collection methods:

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

A comprehensive ophthalmological examination includes:

- Checking visual acuity with Snellen chart - correct with pinhole if indicated;
- Examination for cataract;
- Examination of fundi with pupils dilated.

Source and reference attributes

Submitting organisation:

National Diabetes Data Working Group

Origin:

National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:

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

Supersedes Ophthalmological assessment - outcome, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Implementation in Data Set Specifications:

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

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

Information specific to this data set:

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

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

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

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

Assessment by an ophthalmologist is essential:

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

References:

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

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

US National Eye Institute.

Ophthalmological assessment—outcome (right retina)

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Person—ophthalmological assessment outcome
Definition:	The result of an ophthalmological assessment.
Context:	Public health, health care and clinical settings.
Object class:	Person
Property:	Ophthalmological assessment outcome

Value domain attributes

Representational attributes

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

Permissible values:

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

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

This is a repeating record of both eyes.

1st field - Right retina

2nd field - Left retina

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

Example:

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

Only the result of an assessment carried out in the last 12

months should be recorded.

Collection methods:

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

A comprehensive ophthalmological examination includes:

- Checking visual acuity with Snellen chart - correct with pinhole if indicated;
- Examination for cataract;
- Examination of fundi with pupils dilated.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:

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

Supersedes Ophthalmological assessment - outcome, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Implementation in Data Set Specifications:

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

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

Information specific to this data set:

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

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

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

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

Assessment by an ophthalmologist is essential:

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

References:

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

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

US National Eye Institute.

Ophthalmoscopy performed indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—ophthalmoscopy performed indicator (last 12 months), code N
METeOR identifier:	302821
Registration status:	NHIG, Standard 21/09/2005
Definition:	Whether or not an examination of the fundus of the eye by an ophthalmologist or optometrist, as a part of the ophthalmological assessment, has been undertaken in the last 12 months, as represented by a code.

Data element concept attributes

Data element concept:	Person—ophthalmoscopy performed indicator
Definition:	Whether or not an examination of the fundus of the eye by an ophthalmologist or optometrist as a part of the ophthalmological assessment has been undertaken.
Context:	Public health, health care and clinical settings.
Object class:	Person
Property:	Ophthalmoscopy performed indicator

Source and reference attributes

Submitting organisation:	National diabetes data working group

Value domain attributes

Representational attributes

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

Collection and usage attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes: Record if a fundus examination of eye has occurred. CODE 2 No: Record if a fundus examination of eye has not

occurred.

Collection methods: Ask the individual if he/she has undertaken an eye check, including examination of fundi with pupils dilated. Pupil dilatation and an adequate magnified view of the fundus is essential, using either detailed direct or indirect ophthalmoscopy or fundus camera. This will usually necessitate referral to an ophthalmologist.

Source and reference attributes

Submitting organisation: National diabetes data working group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references: Supersedes Person—ophthalmoscopy performed status (previous 12 months), code N NHIG, Superseded 21/09/2005

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

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

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

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

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

References:

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

Diabetes: complications: Therapeutic Guidelines Limited (05.04.2002).

Organisation end date

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Service provider organisation—organisation end date
Definition:	The date on which an establishment, agency or organisation stopped or concluded operations or practice.
Object class:	Service provider organisation
Property:	Organisation end date

Value domain attributes

Representational attributes

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

Data element attributes

Relational attributes

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

Organisation name

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Service provider organisation (name)—organisation name
Definition:	The appellation by which an establishment, agency or organisation is known or called.
Object class:	Service provider organisation
Property:	Organisation name

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

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

Source and reference attributes

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

Relational attributes

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

Organisation start date

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Service provider organisation—organisation start date
Definition:	The date on which an establishment, agency or organisation started or commenced operations or service.
Object class:	Service provider organisation
Property:	Organisation start date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use:

This field must—

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

Source and reference attributes

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

Relational attributes

Implementation in Data Set Specifications:

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

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

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

of the data.

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

Other drug of concern

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Episode of treatment for alcohol and other drugs—drug of concern
Definition:	The drug of concern during an episode of treatment for alcohol and other drugs.
Context:	Alcohol and other drug treatment services.
Object class:	Episode of treatment for alcohol and other drugs
Property:	Drug of concern

Value domain attributes

Representational attributes

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

Supplementary values:

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

Collection and usage attributes

Guide for use:

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

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

CODE 0005 Opioid analgesics not further defined

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

CODE 0006 Psychostimulants not further defined

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

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

Data element attributes

Collection and usage attributes

Guide for use:

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

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

Collection methods:

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

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

Comments:

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

Source and reference attributes

Submitting organisation:

Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references:

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

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Other treatment type for alcohol and other drugs

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Episode of treatment for alcohol and other drugs—treatment type
Definition:	The type of treatment provided to a client during an episode of treatment for alcohol and other drugs.
Context:	Alcohol and other drug treatment services
Object class:	Episode of treatment for alcohol and other drugs
Property:	Treatment type

Value domain attributes

Representational attributes

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

Permissible values:

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

Collection and usage attributes

Guide for use:

CODE 1 Withdrawal management (detoxification)

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

CODE 2 Counselling

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

CODE 3 Rehabilitation

Refers to an intensive treatment program that integrates a range of services and therapeutic activities that may include

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

CODE 4 Pharmacotherapy

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

Data element attributes

Collection and usage attributes

Guide for use:

To be completed at cessation of treatment episode.

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

More than one code may be selected.

Collection methods:

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

Comments:

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

Source and reference attributes

Submitting organisation:

Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references:

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

Implementation in Data Set Specifications:

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Outcome of initial treatment

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Cancer treatment—outcome of treatment
Definition:	The outcome of initial treatment describes the response of the tumour at the completion of the initial treatment modalities.
Object class:	Cancer treatment
Property:	Outcome of treatment

Value domain attributes

Representational attributes

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

Permissible values:

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

Supplementary values:

Value	Meaning
9.0	Not assessed or unable to be assessed

Collection and usage attributes

Guide for use:

CODE 1.0 Complete response

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

CODE 2.1 Partial response

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

CODE 2.2 Stable or static disease

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

CODE 2.3 Progressive disease

An increase by at least 25% of the sum of the products of the maximum diameter and a perpendicular diameter of any

measurable lesion, or the appearance of new lesions.

Data element attributes

Source and reference attributes

Origin: New South Wales Health Department

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

Relational attributes

Related metadata references: Supersedes Outcome of initial treatment, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Implementation in Data Set Specifications: Cancer (clinical) DSS NHIG, Superseded 07/12/2005

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

Information specific to this data set:
This item is collected for assessing disease status at the end of primary treatment.

Outcome of last previous pregnancy

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Pregnancy (last previous)—pregnancy outcome
Definition:	Outcome of the most recent pregnancy preceding this pregnancy.
Context:	Perinatal statistics
Object class:	Pregnancy
Property:	Pregnancy outcome

Value domain attributes

Representational attributes

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

Permissible values:

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

Data element attributes

Collection and usage attributes

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

factor for subsequent pregnancy.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Outcome of last previous pregnancy, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Outpatient clinic type

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Establishment—outpatient clinic type
Definition:	The organisational unit or organisational arrangement through which a hospital provides healthcare services in an outpatient setting.
Context:	Outpatient service activity.
Object class:	Establishment
Property:	Outpatient clinic type

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Allied Health
2	Dental
3	Gynaecology
4	Obstetrics
5	Cardiology
6	Endocrinology
7	Oncology
8	Respiratory
9	Gastroenterology
10	Medical
11	General practice/primary care
12	Paediatric medical
13	Endoscopy
14	Plastic surgery
15	Urology
16	Orthopaedic surgery
17	Ophthalmology

18	Ear, nose and throat
19	Pre-admission and pre-anaesthesia
20	Chemotherapy
21	Dialysis
22	Surgery
23	Paediatric surgery
24	Renal medical

Collection and usage attributes

Guide for use:

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

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

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

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

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

CODE 1 Allied Health

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

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

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

(see code 5).

CODE 2 Dental

- Dental.

CODE 3 Gynaecology

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

CODE 4 Obstetrics

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

Excludes gestational diabetes (see code 6).

CODE 5 Cardiology

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

Excludes cardiac catheterisation (see code 22).

CODE 6 Endocrinology

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

CODE 7 Oncology

- Oncology.
- Lymphoedema.
- Radiation oncology.

Excludes chemotherapy (see code 20).

Excludes gynaecological oncology (see code 3).

CODE 8 Respiratory

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

CODE 9 Gastroenterology

- Gastroenterology.

Excludes endoscopy (see code 13).

CODE 10 Medical

- Aged care, geriatric, gerontology.
- Allergy.

- Anti-coagulant.
- Clinical Measurement; include with relevant specialty clinic type where clinical measurement services are specific to a specialty (see codes 1-23) e.g. urodynamic analysis is counted with Urology (see code 15).
- Dementia.
- Dermatology.
- Development disability.
- Epilepsy.
- Falls.
- General medicine.
- Genetic.
- Haematology, haemophilia.
- Hepatobiliary.
- Hyperbaric medicine.
- Immunology, HIV.
- Infectious diseases; Communicable diseases; Hep B, C; includes tuberculosis.
- Men's Health.
- Metabolic bone.
- Excludes Nephrology (see code 24); excludes renal (see code 24); excludes dialysis (see code 21).
- Neurology, neurophysiology.
- Occupational medicine.
- Other.
- Pain management
- Palliative.
- Refugee clinic.
- Rehabilitation; excludes cardiac rehabilitation (see code 5).
- Rheumatology.
- Sexual Health.
- Spinal.
- Stoma therapy.
- Transplants (excludes kidney transplants see code 24).
- Wound, Dressing clinic.

CODE 11 General practice / primary care

- General Practice, Primary Care.

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

CODE 12 Paediatric Medical

- Adolescent health.
- Neonatology.
- Paediatric medicine.

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

CODE 13 Endoscopy

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

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

CODE 14 Plastic surgery

- Craniofacial.
- Melanoma.
- Plastic surgery.

CODE 15 Urology

- Urology.

Includes urodynamic measurement and IVPs.

CODE 16 Orthopaedic surgery

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

CODE 17 Ophthalmology

- Ophthalmology.
- Cataract extraction.
- Lens insertion.

CODE 18 Ear, nose and throat

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

CODE 19 Pre-admission and pre-anaesthesia

- Pre-admission.
- Pre-anaesthesia.

CODE 20 Chemotherapy

Includes all forms of chemotherapy.

CODE 21 Dialysis

Dialysis and includes renal dialysis education. See code 24 for Renal medicine

CODE 22 Surgery

- Cardiac.
- Vascular.
- Cardiac catheterisation.
- Colorectal.
- Upper GI surgery.
- General surgery.
- Neurosurgery.
- Other surgery.
- Thoracic surgery.

CODE 23 Paediatric surgery

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

CODE 24 Renal Medical

- Renal Medicine.
- Nephrology.
- Includes pre and post transplant treatment, support and

education.

- Excludes dialysis and renal dialysis education. See code 21

Source and reference attributes

Origin: National Centre for Classification in Health consultant's report to Outpatients National Minimum Data Set Development Working Group, September 2004.

Data element attributes

Collection and usage attributes

Guide for use: Does not include services provided through community health settings (such as community and child health centres).

Source and reference attributes

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

Relational attributes

Related metadata references: See also Establishment—number of occasions of service, total N[NNNNNN] NHIG, Standard 04/07/2007

Supersedes Establishment—outpatient clinic type, code N[N] NHIG, Superseded 04/07/2007

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

Implementation start date: 01/07/2007

Overdue patient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—overdue patient status, code N
METeOR identifier:	270009
Registration status:	NHIG, Standard 01/03/2005
Definition:	Whether or not a patient is an overdue patient, as represented by a code.

Data element concept attributes

Data element concept:	Elective surgery waiting list episode—overdue patient status
Definition:	An overdue patient is one whose wait has exceeded the time that has been determined as clinically desirable in relation to the urgency category to which they have been assigned.
Context:	Elective surgery: The numbers and proportions of overdue patients represent a measure of the hospital's performance in the provision of elective hospital care.
Object class:	Elective surgery waiting list episode
Property:	Overdue patient status

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Overdue patient
2	Other

Data element attributes

Collection and usage attributes

Guide for use:	This metadata item is only required for patients in Elective surgery waiting list episode—clinical urgency, code N categories with specified maximum desirable waiting times. Overdue patients are those for whom the hospital system has failed to provide timely care and whose wait may have an adverse effect on the outcome of their care. They are identified by a comparison of Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] or Elective surgery waiting list episode —waiting time (at a census date), total days N[NNN] and the maximum desirable time limit for the Elective surgery waiting list episode—clinical urgency, code N classification.

A patient is classified as overdue if ready for care and waiting time at admission or waiting time at a census date is longer than 30 days for patients in Elective surgery waiting list episode—clinical urgency, code N category 1 or 90 days for patients in Elective surgery waiting list episode—clinical urgency, code N category 2.

Comments: This metadata item is not used for patients in Elective surgery waiting list episode—clinical urgency, code N category 3 as there is no specified timeframe within which it is desirable that they are admitted. The metadata item Elective surgery waiting list episode—extended wait patient indicator, status code N identifies patients in Elective surgery waiting list episode—clinical urgency, code N category 3 who have waited longer than one year at admission or at the time of a census.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

See also Elective surgery waiting list episode—clinical urgency, code N NHIG, Standard 01/03/2005

Is formed using Elective surgery waiting list episode—waiting time (at a census date), total days N[NNN] NHIG, Standard 01/03/2005

Is formed using Elective surgery waiting list episode—waiting time (at removal), total days N[NNN] NHIG, Standard 01/03/2005

Supersedes Overdue patient, version 3, Derived DE, NHDD, NHIMG, Superseded 01/03/2005

Implementation in Data Set Specifications:

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

Implementation start date: 30/09/2006

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

Implementation start date: 30/09/2002

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

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

Implementation start date: 01/07/2002

Implementation end date: 30/06/2006

Parity

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—parity, total N[N]
METeOR identifier:	302013
Registration status:	NHIG, Standard 29/11/2006
Definition:	The total number of previous pregnancies experienced by the woman that have resulted in a live birth or a stillbirth.

Data element concept attributes

Data element concept:	Female—parity
Definition:	Previous pregnancies that have reached at least 20 weeks gestation.
Context:	Perinatal statistics: The number of previous pregnancies is an important component of the woman's reproductive history. Parity may be a risk factor for adverse maternal and perinatal outcomes.
Object class:	Female
Property:	Parity

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Value domain attributes

Representational attributes

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

Supplementary values:

Value	Meaning
99	Not stated

Unit of measure:	Pregnancy

Data element attributes

Collection and usage attributes

Guide for use:

This is to be recorded for each pregnancy.

This data element includes live births and stillbirths of 20 weeks gestation or 400 grams birthweight.

This data element excludes:

- the current pregnancy;
- pregnancies resulting in spontaneous or induced abortions before 20 weeks gestation; and
- ectopic pregnancies.

A primigravida (a woman pregnant for the first time) has a parity of 0.

Collection methods: A pregnancy with multiple fetuses is counted as one pregnancy.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Patient days

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of patient days, total N[N(7)]
METeOR identifier:	270045
Registration status:	NHIG, Standard 01/03/2005
Definition:	The total number of days for all patients who were admitted for an episode of care and who separated during a specified reference period.

Data element concept attributes

Data element concept:	Establishment—number of patient days
Definition:	The number of days for all patients who were admitted for an episode of care and who separated during a specified reference period.
Context:	Admitted patient care
Object class:	Establishment
Property:	Number of patient days

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N(7)]
Maximum character length:	8
Unit of measure:	Day

Data element attributes

Collection and usage attributes

Guide for use:

A day is measured from midnight to 2359 hours.

The following basic rules are used to calculate the number of patient days for **overnight stay patients**:

- The day the patient is admitted is a patient day
- If the patient remains in hospital from midnight to 2359 hours count as a patient day
- The day a patient goes on leave is counted as a leave day
- If the patient is on leave from midnight to 2359 hours count as a leave day
- The day the patient returns from leave is counted as a patient day
- The day the patient is separated is not counted as a patient day.

The following additional rules cover special circumstances and in such cases, override the basic rules:

- Patients admitted and separated on the same date (**same-**

day patients) are to be given a count of one patient day

- If the patient is admitted and goes on leave on the same day, count as a patient day
- If the patient returns from leave and goes on leave on the same date, count as a leave day.
- If the patient returns from leave and is separated, it is not counted as either a patient day or a leave day.
- If a patient goes on leave the day they are admitted and does not return from leave until the day they are discharged, count as one patient day (the day of admission is counted as a patient day, the day of separation is not counted as a patient day).

When calculating total patient days for a specified period:

- Count the total patient days of those patients separated during the specified period including those admitted before the specified period
- Do not count the patient days of those patients admitted during the specified period who did not separate until the following reference period
- Contract patient days are included in the count of total patient days. If it is a requirement to distinguish contract patient days from other patient days, they can be calculated by using the rules contained in the data element: total contract patient days.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Is formed using Episode of admitted patient care (newborn)—number of qualified days, total N[NNNN] NHIG, Standard 01/03/2005

Supersedes Patient days, version 3, Derived DE, NHDD, NHIMG, Superseded 01/03/2005

Patient listing status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—patient listing status, readiness for care code N
METeOR identifier:	269996
Registration status:	NHIG, Standard 01/03/2005
Definition:	An indicator of the person's readiness to begin the process leading directly to being admitted to hospital for the awaited procedure, as represented by a code.

Data element concept attributes

Data element concept:	Elective surgery waiting list episode—patient listing status
Definition:	An indicator of the person's readiness to begin the process leading directly to being admitted to hospital for the awaited procedure.
Object class:	Elective surgery waiting list episode
Property:	Patient listing status

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Ready for care
2	Not ready for care

Data element attributes

Collection and usage attributes

Guide for use:

A patient may be 'ready for care' or 'not ready for care'. Ready for care patients are those who are prepared to be admitted to hospital or to begin the process leading directly to admission. These could include investigations/procedures done on an outpatient basis, such as autologous blood collection, pre-operative diagnostic imaging or blood tests. Not ready for care patients are those who are not in a position to be admitted to hospital. These patients are either:

- staged patients whose medical condition will not require or be amenable to surgery until some future date; for example, a patient who has had internal fixation of a fractured bone and who will require removal of the fixation device after a suitable time; or
- deferred patients who for personal reasons are not yet prepared to be admitted to hospital; for example, patients

with work or other commitments which preclude their being admitted to hospital for a time.

Not ready for care patients could be termed staged and deferred waiting list patients, although currently health authorities may use different terms for the same concepts.

Staged and deferred patients should not be confused with patients whose operation is postponed for reasons other than their own unavailability; for example, surgeon unavailable, operating theatre time unavailable owing to emergency workload. These patients are still 'ready for care'.

Periods when patients are not ready for care should be excluded in determining 'Waiting time (at removal)' and 'Waiting time (at a census date)'.

Comments:

Only patients ready for care are to be included in the National Minimum Data Set - Elective surgery waiting times. The dates when a patient listing status changes need to be recorded. A patient's classification may change if he or she is examined by a clinician during the waiting period, i.e. undergoes **clinical review**. The need for clinical review varies with the patient's condition and is therefore at the discretion of the treating clinician. The waiting list information system should be able to record dates when the classification is changed (metadata item Category reassignment date).

At the Waiting Times Working Group meeting on 9 September 1996, it was agreed to separate the metadata items Patient listing status, readiness for care and Clinical urgency as the combination of these items had led to confusion.

Source and reference attributes

Submitting organisation:

Hospital Access Program Waiting Lists Working Group

Waiting Times Working Group

Origin:

National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Patient listing status, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005

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

Patient present status (non-admitted patient)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Non-admitted patient service event—patient present status, code N
METeOR identifier:	270081
Registration status:	NHIG, Standard 01/03/2005
Definition:	The presence or absence of a patient at a service event, as represented by a code.

Data element concept attributes

Data element concept:	Non-admitted patient service event—patient present status
Definition:	The presence or absence of a patient at a service event.
Context:	Hospital non-admitted patient care
Object class:	Non-admitted patient service event
Property:	Patient present status

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Patient present with or without carer(s)/relative(s)
2	Carer(s)/relative(s) of the patient only

Data element attributes

Collection and usage attributes

Guide for use: A service event is regarded as having occurred when a consultation occurs between their carer/relative and a service provider at an appointment when the patient is not present, provided that the carer/relative is not a patient in their own right for the service contact. Where both are patients, it is considered that service events have been provided for the person(s) in whose medical record the service event is noted.

Relational attributes

Related metadata references: Supersedes Non-admitted patient service event - patient present status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Patients in residence at year end

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—patients / clients in residence at year end, total N[NNN]
METeOR identifier:	270046
Registration status:	NHIG, Standard 01 / 03 / 2005
Definition:	A headcount of all formally admitted patients / clients in residence in long-stay facilities.

Data element concept attributes

Data element concept:	Establishment—patients / clients in residence at year end
Definition:	A headcount of all formally admitted patients / clients in residence in long-stay facilities (public psychiatric hospitals, alcohol and drug hospitals, residential aged care services) at midnight, to be done on 30 June.
Object class:	Establishment
Property:	Patients / clients in residence at year end

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Collection methods:	For public psychiatric hospitals and alcohol and drug hospitals, all states have either an annual census or admission tracking that would enable a statistical census. The Commonwealth Department of Health and Ageing is able to carry out a statistical census from its residential aged care service databases. A headcount snapshot could be achieved either by census or by the admission / discharge derivation approach. There are difficulties with the snapshot in view of both seasonal and day of the week fluctuations. Most of the traffic occurs in a small number of beds. Any headcount should avoid the problems associated with using 31 December or 1 January. The end of the normal financial year is probably more sensible (the Wednesday before the end of the financial year was suggested, but probably not necessary). This should be qualified by indicating that the data does not form a time series in its own right.

Comments: The number of separations and bed days for individual long-stay establishments is often a poor indication of the services provided. This is because of the relatively small number of separations in a given institution. Experience has shown that the number of patients/clients in residence can often give a more reliable picture of the levels of services being provided.

Source and reference attributes

Submitting organisation: Morbidity working party

Relational attributes

Related metadata references: Supersedes Patients in residence at year end, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005

Perineal status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female (mother)—postpartum perineal status, code N
METeOR identifier:	269939
Registration status:	NHIG, Standard 01/03/2005
Definition:	The state of the perineum following birth, as represented by a code.
Context:	Perinatal

Data element concept attributes

Data element concept:	Female (mother)—postpartum perineal status
Definition:	State of the perineum following birth.
Object class:	Female
Property:	Postpartum perineal status

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Intact
2	1st degree laceration/vaginal graze
3	2nd degree laceration
4	3rd degree laceration
5	Episiotomy
6	Combined laceration and episiotomy
7	4th degree laceration
8	Other

Supplementary values:

9	Not stated

Collection and usage attributes

Guide for use:	Vaginal tear is included in the same group as 1st degree laceration to be consistent with ICD-10-AM code. Other degrees of laceration are as defined in ICD-10-AM.
Comments:	While 4th degree laceration is more severe than an episiotomy it has not been placed in order of clinical significance within the data domain. Instead it has been added to the data domain as a new code rather than modifying the existing order of data domain code values. This is because information gatherers are accustomed to the existing order of the codes. Modifying the existing order may result in miscoding of data. This approach is consistent with established practice in classifications wherein a

new data domain identifier (or code number) is assigned to any new value meaning that occurs, rather than assigning this new value domain meaning to an existing data domain identifier.

Data element attributes

Collection and usage attributes

Comments: Perineal laceration (tear) may cause significant maternal morbidity in the postnatal period. Episiotomy is an indicator of management during labour and, to some extent, of intervention rates.

Relational attributes

Related metadata references: Supersedes Perineal status, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005

Period of residence in Australia

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—period of residence in Australia, years code NN
METeOR identifier:	270050
Registration status:	NHIG, Standard 01/03/2005
Definition:	Length of time in years a person has lived in Australia.

Data element concept attributes

Data element concept:	Person—period of residence in Australia
Definition:	Length of time a person has lived in Australia.
Object class:	Person
Property:	Period of residence in Australia

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
00	Under one year residence in Australia
01-97	1 to 97 years residence in Australia
98	Born in Australia

Supplementary values:

99	Unknown

Data element attributes

Collection and usage attributes

Collection methods:

This information may be obtained either from:

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

Comments:

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

This item was not considered a high priority by the Office of Multicultural Affairs (1988) and to date only the country of birth and Indigenous status are considered by the National Health Data Committee to be justified for inclusion in the National Minimum Data Set - Admitted patient care.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes Period of residence in Australia, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Peripheral neuropathy (status)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—peripheral neuropathy indicator, code N
METeOR identifier:	302457
Registration status:	NHIG, Standard 21/09/2005
Definition:	Whether peripheral neuropathy is present, as represented by a code.

Data element concept attributes

Data element concept:	Person—peripheral neuropathy indicator
Definition:	The outcome of assessment for the presence of peripheral neuropathy.
Context:	Public health, health care and clinical settings.
Object class:	Person
Property:	Peripheral neuropathy indicator

Value domain attributes

Representational attributes

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

Collection and usage attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes: Record if peripheral neuropathy is present in the person. CODE 2 No: Record if peripheral neuropathy is not present in the person. Record whether or not peripheral neuropathy is present determined by clinical judgement following assessment using pinprick and vibration (using perhaps a Biothesiometer) or Monofilament.
Collection methods:	Examine for neuropathy by testing reflexes and sensation preferably using tuning fork (standard vibration fork 128 hz),

pinprick, 10g monofilament and/or biothesiometer.

The preferred assessment methods are monofilament and biothesiometer. These two non-invasive tests provide more objective and repeatable results than testing sensation with pinprick or a tuning fork, which are very difficult to standardise.

1 The 'Touch-Test' Sensory Evaluation (Semmens-Weinstein Monofilaments) application guidelines:

- Occlude the patient's vision by using a shield or by having the patient look away or close his or her eyes.
- Instruct the patient to respond when a stimulus is felt by saying 'touch' or 'yes'.
- Prepare to administer the stimulus to the foot (dorsal or plantar surface).
- Press the filament of the Touch
- Test at a 90 degree angle against the skin until it bows. Hold in place for approximately 1.5 seconds and then remove.

To assure the validity of the sensory test findings:

- The patient must not be able to view the administration of the stimuli so that false indications are avoided.
- The nylon filament must be applied at a 90 degree angle against the skin until it bows for approximately 1.5 second before removing.
- If the patient does not feel the filament, then protective pain sensation has been lost.

2 Testing vibration sensation with a biothesiometer - application guidelines:

- The biothesiometer has readings from 0 to 50 volts. It can be made to vibrate at increasing intensity by turning a dial.
- A probe is applied to part of the foot, usually on the big toe.
- The person being tested indicates as soon as he/she can feel the vibration and the reading on the dial at that point is recorded.

The reading is low in young normal individuals (i.e. they are very sensitive to vibration). In older individuals, the biothesiometer reading becomes progressively higher. From experience, it is known that the risk of developing a neuropathic ulcer is much higher if a person has a biothesiometer reading greater than 30-40 volts.

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group
Origin:	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary
Reference documents:	1997 North Coast Medical, INC. San Jose, CA 95125; 800 821 - 9319 Duffy MD, John C and Patout MD, Charles A. 1990. 'Management of the Insensitive Foot in Diabetes: Lessons from Hansen's Disease'. Military Medicine, 155:575-579 Bell- Krotovski OTR, FAOT, FAOTA, Judith and Elizabeth Tomancik LOTR. 1987. The Repeatability of testing with Semmens-Weinstein Monofilaments. 'The Journal of Hand Surgery,' 12A: 155 - 161

Edmonds M, Boulton A, Buckenham T, et al. Report of the Diabetic Foot and Amputation Group. Diabet Med 1996; 13: S27 - 42

Foot Examination -an interactive guide; Aust Prescr 2002; 25:8 - 10

Relational attributes

Related metadata references:

Supersedes Person—peripheral neuropathy status, code N NHIG, Superseded 21/09/2005

Implementation in Data Set Specifications:

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

Information specific to this data set:

The most important aspect of grading diabetic neuropathy from a foot ulceration point of view is to assess the degree of loss of sensation in the feet.

Diabetic neuropathy tends to occur in the setting of long-standing hyperglycaemia.

Peripheral neuropathy, which affects about 30% of people with either type 1 or type 2 diabetes, is the major predisposing disorder for diabetic foot disease. Peripheral neuropathy in feet results in loss of sensation and autonomic dysfunction. Neuropathy can occur either alone (neuropathic feet) or in combination with peripheral vascular disease causing ischaemia (neuro-ischaemic feet). Purely ischaemic feet are unusual, but are managed in the same way as neuro-ischaemic feet (see Australian Diabetes Society - Position Statement - The Lower Limb in People With Diabetes).

As stated by Duffy and others, the rate of lower extremity amputations can be reduced by 50% by the institution of monofilament testing in a preventive care program.

Diabetes polyneuropathy is frequently asymptomatic but may be associated with numbness, tingling and paraesthesia in the extremities, and less often with hyperesthesias. The most common form is a distal, symmetric, predominantly sensory polyneuropathy, which begins and is usually most marked in the feet and legs.

If symptomatic neuropathy is present consult with endocrinologist or physician specialising in diabetes care since options are available for the relief of symptoms.

Peripheral nerve function should be checked at least yearly in the patient with diabetes.

Peripheral vascular disease in feet (status)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—peripheral vascular disease indicator (foot), code N
METeOR identifier:	302459
Registration status:	NHIG, Standard 21/09/2005
Definition:	Whether peripheral vascular disease is present in either foot, as represented by a code.

Data element concept attributes

Data element concept:	Person—peripheral vascular disease indicator (foot)
Definition:	The outcome of assessment for the presence of peripheral vascular disease in either foot.
Object class:	Person
Property:	Peripheral vascular disease indicator

Value domain attributes

Representational attributes

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

Collection and usage attributes

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

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes: Record if peripheral vascular disease is present in either foot. CODE 2 No: Record if peripheral vascular disease is not present in either foot.
Collection methods:	If it is mild, peripheral vascular disease can be completely without symptoms. However, compromised blood supply in the long term could cause claudication (pain in the calf after walking for a distance or up an incline or stairs), rest pain or vascular ulceration. Physical examination is necessary to assess the peripheral vascular circulation. Purplish colour and cold temperature of feet are indications to suspect that the circulation may be

impaired.

Palpate pulses:

The simplest method to estimate blood flow and to detect ischaemia to the lower extremities is palpation of the foot pulses (posterior tibial and dorsalis pedis arteries) in both feet. Note whether pulses are present or absent. If pulses in the foot can be clearly felt, the risk of foot ulceration due to vascular disease is small.

Test capillary return:

A helpful confirmation sign of arterial insufficiency is pallor of the involved feet after 1 - 2 min of elevation if venous filling time is delayed beyond the normal limit of 15 sec.

Doppler probe:

If pulses cannot be palpated, apply a small hand-held Doppler, placed over the dorsalis pedis or posterior tibial arteries to detect pulses, quantify the vascular supply and listen to the quality of the signal.

When the foot pulses are very weak or not palpable, the risk assessment could be completed by measuring the ankle brachial index (ankle pressure/ brachial pressure). Normal ankle brachial index is 0.9 - 1.2. An ankle brachial index less than 0.6 indicates compromised peripheral circulation.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references: Supersedes Person—peripheral vascular disease status (foot), code N NHIG, Superseded 21/09/2005

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

Information specific to this data set:

Peripheral vascular disease is the leading cause of occlusion of blood vessels of the extremities with increasing prevalence in individuals with hypertension, hypercholesterolemia and diabetes mellitus, and in cigarette smokers.

Peripheral vascular disease is estimated to occur 11 times more frequently and develop about 10 years earlier in people with diabetes.

Presence of symptomatic peripheral vascular disease requires an interdisciplinary approach including a vascular surgeon, an endocrinologist or physician specialising in diabetes care.

References:

Foot Examination - an interactive guide; Australian Prescriber

Person identifier

Identifying and definitional attributes

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

Data element concept attributes

Data element concept:	Person—person identifier
Definition:	Person identifier unique within an establishment or agency.
Context:	This item could be used for editing at the agency, establishment or collection authority level and, potentially, for record linkage. There is no intention that this item would be available beyond collection authority level.
Object class:	Person
Property:	Person identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	XXXXXX[X(14)]
Maximum character length:	20

Data element attributes

Collection and usage attributes

Guide for use:	Individual agencies, establishments or collection authorities may use their own alphabetic, numeric or alphanumeric coding systems. Field cannot be blank.

Source and reference attributes

Reference documents:	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references:	Supersedes Person—person identifier (within establishment/agency), XXXXXX[X(14)] NHIG, Superseded 04/05/2005, NCSIMG, Superseded 25/08/2005
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS NHIG, Standard

07 / 12 / 2005

Implementation start date: 07 / 12 / 2005

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

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

Implementation start date: 01 / 07 / 2005

Implementation end date: 30 / 06 / 2006

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

Implementation start date: 01 / 07 / 2006

Implementation end date: 30 / 06 / 2007

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

Implementation start date: 01 / 07 / 2007

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

Implementation start date: 01 / 07 / 2005

Implementation end date: 30 / 06 / 2006

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

Implementation start date: 01 / 07 / 2006

Implementation end date: 30 / 06 / 2007

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

Implementation start date: 01 / 07 / 2007

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

Implementation start date: 01 / 07 / 2005

Implementation end date: 30 / 06 / 2006

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

Implementation start date: 01 / 07 / 2006

Implementation end date: 30 / 06 / 2007

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

Implementation start date: 01 / 07 / 2007

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

Implementation start date: 01 / 07 / 2005

Implementation end date: 30 / 06 / 2006

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

Implementation start date: 01 / 07 / 2006

Implementation end date: 30 / 06 / 2007

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

Implementation start date: 01 / 07 / 2007

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

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

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

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

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

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

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

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

Information specific to this data set:
Field cannot be blank.

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

Information specific to this data set:
Field cannot be blank.

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

Information specific to this data set:
Field cannot be blank.

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

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Perinatal NMDS NHIG, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Perinatal NMDS NHIG, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

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

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

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

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

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

Implementation start date: 01/07/2007

Person identifier type—health care (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (identifier)—identifier type, geographic / administrative scope code A
METeOR identifier:	270053
Registration status:	NHIG, Standard 01 / 03 / 2005
Definition:	A code based on the geographical or administrative breadth of applicability of Person identifier.

Data element concept attributes

Data element concept:	Person (identifier)—identifier type
Definition:	The geographical or administrative breadth of applicability of Person identifier.
Object class:	Person
Property:	Identifier type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A
Maximum character length:	1

Permissible values:

Value	Meaning
L	Local
A	Area / region / district
S	State or territory

Collection and usage attributes

Guide for use:

CODE L Local

This code is for an identifier that is applicable only inside the issuing health care establishment

CODE A Area / region / district

This code is for an identifier that is applicable to:

- all the area / region / district health care services but not across all services in the state or territory; or
- all of a specific health care service (e.g. community mental health) in an area / region / district health care services but not across all those services in the state or territory

CODE S State or territory

This code is for identifiers that are applicable across all state or territory health care services.

Data element attributes

Collection and usage attributes

Guide for use:

A person can have more than one person identifier. Each Person identifier must have an appropriate person identifier type code recorded.

Use this field to record only identifier type. It must not be used to record any other person related information.

Source and reference attributes

Submitting organisation: Standards Australia

Origin: AS5017 Health Care Client Identification

Relational attributes

Related metadata references: Supersedes Person identifier type - health care, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Implementation in Data Set Specifications: Health care client identification NHIG, Superseded 04/05/2005

Implementation start date: 01/01/2003

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

Physical activity sufficiency status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—physical activity sufficiency status, code N
METeOR identifier:	270054
Registration status:	NHIG, Standard 01/03/2005
Definition:	Sufficiency of moderate or vigorous physical activity to confer a health benefit, as represented by a code.

Data element concept attributes

Data element concept:	Person—physical activity sufficiency status
Definition:	Sufficiency of moderate or vigorous physical activity to confer a health benefit.
Context:	Public health, health care and clinical setting: To monitor health risk factors for national health priority areas and other chronic diseases.
Object class:	Person
Property:	Physical activity sufficiency status

Value domain attributes

Representational attributes

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

Permissible values:

Value	Meaning
1	Sufficient
2	Insufficient
3	Sedentary

Supplementary values:

9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

Guide for use:

The clinician makes a judgment based on assessment of the person's reported physical activity history for a usual 7-day period where:

CODE 1:

Sufficient physical activity for health benefit for a usual 7-day period is calculated by summing the total minutes of walking, moderate and/or vigorous physical activity.

Vigorous physical activity is weighted by a factor of two to account for its greater intensity. Total minutes for health benefit need to be equal to or more than 150 minutes per week.

CODE 2:

Insufficient physical activity for health benefit is where the sum of the total minutes of walking, moderate and / or vigorous physical activity for a usual 7-day period is less than 150 minutes but more than 0 minutes.

CODE 3:

Sedentary is where there has been no moderate and / or vigorous physical activity during a usual 7-day period.

CODE 9:

There is insufficient information to more accurately define the person's physical activity sufficiency status or the information is not known.

Note: The National Heart Foundation of Australia and the National Physical Activity Guidelines for Australians describes moderate-intensity physical activity as causing a slight but noticeable, increase in breathing and heart rate and suggests that the person should be able to comfortably talk but not sing. Examples of moderate physical activity include brisk walking, low pace swimming, light to moderate intensity exercise classes. Vigorous physical activity is described as activity, which causes the person to 'huff and puff', and where talking in a full sentence between breaths is difficult.

Examples of vigorous physical activity include jogging, swimming (freestyle) and singles tennis.

Comments:

The above grouping subdivides a population into three mutually exclusive categories.

A sufficiently physically active person is a person who is physically active on a regular weekly basis equal to or in excess of that required for a health benefit. Sufficient physical activity for health results from participation in physical activity of adequate duration and intensity. Although there is no clear absolute threshold for health benefit, the accrual of 150 minutes of moderate (at least) intensity physical activity over a period of one week is thought to confer health benefit. Walking is included as a moderate intensity physical activity. Note that the 150 minutes of moderate physical activity should be made up of 30 minutes on most days of the week and this can be accumulated in 10 minute bouts (National Physical Activity Guidelines for Australians).

Health benefits can also be obtained by participation in vigorous physical activity, in approximate proportion to the total amount of activity performed, measured either as energy expenditure or minutes of physical activity (Pate et al. 1995).

Physical activity - health benefit for vigorous physical activity is calculated by:

- incorporating a weighted factor of 2, to account for its greater intensity
- summing the total minutes of walking, moderate and / or vigorous physical activity will then give an indication if a health benefit is likely.

Insufficient physical activity describes a person who engages in regular weekly physical activity but not to the level required for a health benefit through either moderate or vigorous physical activity.

A sedentary person is a person who does not engage in any regular weekly physical activity.

Source and reference attributes

Submitting organisation:	Cardiovascular Data Working Group
Origin:	The National Heart Foundation of Australia's Physical Activity Policy, April 2001. National Physical Activity Guidelines For Australians, developed by the University of Western Australia & the Centre for Health Promotion

Relational attributes

Related metadata references:	Supersedes Physical activity sufficiency status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005
Implementation in Data Set Specifications:	Cardiovascular disease (clinical) DSS NHIG, Superseded 15/02/2006 Cardiovascular disease (clinical) DSS NHIG, Superseded 04/07/2007 Cardiovascular disease (clinical) DSS NHIG, Standard 04/07/2007

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

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—place of occurrence, code (ICD-10-AM 5th edn) ANN{.N[N]}
METeOR identifier:	333874
Registration status:	NHIG, Standard 07/12/2005
Definition:	The place where the external cause of injury, poisoning or adverse effect occurred, as represented by a code.

Data element concept attributes

Data element concept:	Injury event—place of occurrence
Definition:	The place where the external cause of injury, poisoning or adverse effect occurred.
Object class:	Injury event
Property:	Place of occurrence

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 5th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:	Admitted patient: Use External Causes of Morbidity and Mortality Place of Occurrence codes from the current edition of ICD-10-AM. Used with all ICD-10-AM external cause codes and assigned according to the Australian Coding Standards. External cause codes in the range W00 to Y34, except Y06 and Y07 must be accompanied by a place of occurrence code. External cause codes V01 to Y34 must be accompanied by an activity code.
Comments:	Enables categorisation of injury and poisoning according to factors important for injury control. Necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research.

Source and reference attributes

Origin:

National Health Data Committee

National Centre for Classification in Health

AIHW National Injury Surveillance Unit

National Data Standards for Injury Surveillance Advisory Group

Relational attributes

Related metadata references:

Supersedes Injury event—place of occurrence, code (ICD-10-AM 4th edn) ANN{.N[N]} NHIG, Superseded 07/12/2005

Implementation in Data Set Specifications:

Admitted patient care NMDS 2006-2007 NHIG, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006

Implementation start date: 01/07/2007

Information specific to this data set:
To be used with ICD-10-AM external cause codes.
Effective for collection from 01/07/2006

Injury surveillance DSS NHIG, Standard 03/05/2006

Information specific to this data set:
Effective for collection from 01/07/2006

Injury surveillance NMDS NHIG, Superseded 03/05/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Place of occurrence of external cause of injury (non-admitted patient)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—place of occurrence, non-admitted patient code N[N]
METeOR identifier:	268949
Registration status:	NHIG, Standard 01/03/2005
Definition:	The place where the external cause of injury, poisoning or adverse effect occurred, as represented by a code.

Data element concept attributes

Data element concept:	Injury event—place of occurrence
Definition:	The place where the external cause of injury, poisoning or adverse effect occurred.
Object class:	Injury event
Property:	Place of occurrence

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
0	Home
1	Residential Institution
2	School, other institution and public administration area
21	School
22	Health service area
23	Building used by general public or public group
3	Sports and athletics area
4	Street and highway
5	Trade and service area
6	Industrial and construction area
7	Farm
8	Other specified places

Supplementary values:

9	Unspecified place

Data element attributes

Collection and usage attributes

Guide for use: To be used for injury surveillance purposes for non-admitted patients when it is not possible to use ICD-10-AM codes. Select the code which best characterises the type of place where the person was situated when the injury occurred on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one that comes first in the code list.

Source and reference attributes

Origin: National Centre for Classification in Health
AIHW National Injury Surveillance Unit
National Data Standards for Injury Surveillance Advisory Group
National Health Data Committee

Relational attributes

Related metadata references: Supersedes Place of occurrence of external cause of injury, version 6, DE, NHDD, NHIMG, Superseded 01/03/2005

Implementation in Data Set Specifications: Injury surveillance DSS NHIG, Standard 03/05/2006
Injury surveillance NMDS NHIG, Superseded 03/05/2006
Implementation start date: 01/07/2005
Implementation end date: 30/06/2006
Injury surveillance NMDS NHIG, Superseded 07/12/2005

Postal delivery point identifier (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—postal delivery point identifier, {N(8)}
METeOR identifier:	287220
Registration status:	NHIG, Standard 04/05/2005 NCSIMG, Standard 25/08/2005
Definition:	A unique number assigned to a person's postal address as recorded on the Australia Post Postal Address File (PAF).

Data element concept attributes

Data element concept:	Person (address)—postal delivery point identifier
Definition:	A unique number assigned to a person's postal address as recorded on the Australia Post Postal Address File (PAF).
Object class:	Person
Property:	Postal delivery point identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	Number
Format:	{N(8)}
Maximum character length:	8

Source and reference attributes

Origin:	Customer Barcoding Technical Specifications, 1998: Australia Post
Reference documents:	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Data element attributes

Collection and usage attributes

Guide for use:	Australia Post maintains a Postal Address File (PAF) database which contains Australian postal delivery addresses and their corresponding eight (8) character unique identification number known as a Delivery Point Identifier (DPID). While the PAF is concerned with postal address, for many persons' a postal address will be the same as their residential address. The PAF can be used to improve the recording of address data at the time of data collection. The Postal Address File may be used at the time of data collection to confirm that the combined metadata items of address line, suburb/town/locality, Australian state/territory identifier and postcode - Australian are accurately recorded.

Collection methods:

The Delivery Point Identifier (DPID) is assigned electronically to recognised Australia Post delivery addresses following reference to the Postal Address File (PAF) database.

Comments:

In October 1999, Australia Post introduced a bar-coding system for bulk mail lodgements. Agencies or establishments can use software to improve the quality of person address data it collects and records and, at the same time, receive financial benefits by reducing its postage expenses.

The DPID is easily converted to a bar code and can be included on correspondence and address labels. If the bar code is displayed on a standard envelope that passes through a mail-franking machine (e.g. as used by most major hospitals), the postage cost is reduced. Every three months, Australia Post provides updates to the PAF database. For more information, contact Australia Post.

Source and reference attributes

Submitting organisation:

Standards Australia

Origin:

National Health Data Standards Committee

National Community Services Data Committee

Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Relational attributes

Related metadata references:

Is formed using Person (address)—suburb / town / locality name, text [A(50)] NHIG, Standard 04 / 05 / 2005, NCSIMG, Standard 25 / 08 / 2005

Supersedes Person (address)—postal delivery point identifier, {N(8)} NHIG, Superseded 04 / 05 / 2005, NCSIMG, Superseded 25 / 08 / 2005

Implementation in Data Set Specifications:

Health care client identification DSS NHIG, Standard 04 / 05 / 2005

Health care provider identification DSS NHIG, Superseded 04 / 07 / 2007

Health care provider identification DSS NHIG, Standard 04 / 07 / 2007

Postal delivery point identifier (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—postal delivery point identifier, {N(8)}
METeOR identifier:	290141
Registration status:	NHIG, Standard 04/05/2005 NCSIMG, Standard 31/08/2005
Definition:	A unique number assigned to a service provider organisation's postal address as recorded on the Australia Post Postal Address File (PAF).

Data element concept attributes

Data element concept:	Service provider organisation (address)—postal delivery point identifier
Definition:	A unique number assigned to a service provider organisation's postal address as recorded on the Australia Post Postal Address File (PAF).
Object class:	Service provider organisation
Property:	Postal delivery point identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	Number
Format:	{N(8)}
Maximum character length:	8

Source and reference attributes

Origin:	Customer Barcoding Technical Specifications, 1998: Australia Post
Reference documents:	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Data element attributes

Collection and usage attributes

Collection methods:	The Delivery Point Identifier (DPID) is assigned electronically to recognised Australia Post delivery addresses following reference to the Postal Address File (PAF) database.
Comments:	In October 1999, Australia Post introduced a bar-coding system for bulk mail lodgements. Agencies or establishments can use software to improve the quality of person address data it collects and records and, at the same time, receive financial

benefits by reducing its postage expenses.

The DPID is easily converted to a bar code and can be included on correspondence and address labels. If the bar code is displayed on a standard envelope that passes through a mail-franking machine (e.g. as used by most major hospitals), the postage cost is reduced. Every three months, Australia Post provides updates to the PAF database. For more information, contact Australia Post.

Source and reference attributes

Submitting organisation: Standards Australia

Origin: National Health Data Standards Committee

National Community Services Data Committee

Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Relational attributes

Related metadata references: Is formed using Service provider organisation (address)—suburb / town / locality name, text [A(50)] NHIG, Standard 04 / 05 / 2005, NCSIMG, Standard 31 / 08 / 2005

Implementation in Data Set Specifications: Health care provider identification DSS NHIG, Superseded 04 / 07 / 2007

Health care provider identification DSS NHIG, Standard 04 / 07 / 2007

Postal delivery service number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—postal delivery service type identifier, [X(11)]
METeOR identifier:	270032
Registration status:	NHIG, Standard 01/03/2005
Definition:	An identifier for the postal delivery service where a person is located.

Data element concept attributes

Data element concept:	Person (address)—postal delivery service type identifier
Definition:	An identifier for the postal delivery service where a person is located.
Object class:	Person
Property:	Postal delivery service type identifier

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	[X(11)]
Maximum character length:	11

Data element attributes

Collection and usage attributes

Guide for use:	The identification of a postal delivery service may be composed of a prefix, a number, and a suffix as per the following format: Prefix A(3) Number N(5) Suffix A(3) May optionally include a prefix and suffix which are non-numeric. The identification may also not be required for certain services. Examples: PO BOX C96 CARE PO RMB 123 GPO BOX 1777Q
Collection methods:	To be collected in conjunction with Postal delivery service type - abbreviation.

Source and reference attributes

Origin: Health Data Standards Committee
AS4590 Interchange of client information

Relational attributes

Related metadata references: Supersedes Postal delivery service number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Postal delivery service type - abbreviation

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—postal delivery service type, code AA[A(9)]
METeOR identifier:	270027
Registration status:	NHIG, Standard 01/03/2005
Definition:	Type of postal delivery service for a person, as represented by a code.

Data element concept attributes

Data element concept:	Person—postal delivery service type
Definition:	Type of postal delivery service for a person.
Context:	Australian addresses
Object class:	Person
Property:	Postal delivery service type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	AA[A(9)]
Maximum character length:	11

Permissible values:

Value	Meaning
CARE PO	Care-of Post Office (also known as Poste Restante)
CMA	Community Mail Agent
CMB	Community Mail Bag
GPO BOX	General Post Office Box
LOCKED BAG	Locked Mail Bag Service
MS	Mail Service
PO BOX	Post Office Box
PRIVATE BAG	Private Mail Bag Service
RSD	Roadside Delivery
RMB	Roadside Mail Box/Bag
RMS	Roadside Mail Service

Collection and usage attributes

Collection methods:	To be collected in conjunction with Person (address)—postal delivery service type identifier, [X(11)] when applicable.

Source and reference attributes

Origin: AS4590 Interchange of client information

Data element attributes

Source and reference attributes

Origin: Health Data Standards Committee

Relational attributes

Related metadata references: Supersedes Postal delivery service type - abbreviation, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Postcode—Australian (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—Australian postcode, code (Postcode datafile) {NNNN}
METeOR identifier:	287224
Registration status:	NHIG, Standard 04/05/2005 NCSIMG, Standard 25/08/2005 NHDAMG, Standard 10/02/2006
Definition:	The numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of a person.

Data element concept attributes

Data element concept:	Person (address)—Australian postcode
Definition:	The numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of a person.
Context:	Postcode is an important part of a person's postal address and facilitates written communication. It is one of a number of geographic identifiers that can be used to determine a geographic location. Postcode may assist with uniquely identifying a person.
Object class:	Person
Property:	Australian postcode

Value domain attributes

Representational attributes

Classification scheme:	Postcode datafile
Representation class:	Code
Data type:	Number
Format:	{NNNN}
Maximum character length:	4

Collection and usage attributes

Comments:	Postcode - Australian may be used in the analysis of data on a geographical basis, which involves a conversion from postcodes to the Australian Bureau of Statistics (ABS) postal areas. This conversion results in some inaccuracy of information. However, in some data sets postcode is the only geographic identifier, therefore the use of other more accurate indicators (e.g. Statistical Local Area (SLA)) is not always possible. When dealing with aggregate data, postal areas, converted from postcodes, can be mapped to Australian Standard Geographical Classification codes using an ABS concordance, for example to determine SLAs. It should be noted that such concordances should not be used to determine the SLA of any individual's postcode. Where individual street addresses are available, these can be mapped to ASGC codes (e.g. SLAs) using the ABS National Localities Index (NLI).

Data element attributes

Collection and usage attributes

Guide for use:

The postcode book is updated more than once annually as postcodes are a dynamic entity and are constantly changing.

Collection methods:

Leave Postcode - Australian blank for:

- Any overseas address
- Unknown address
- No fixed address.

May be collected as part of Address line or separately. Postal addresses may be different from where a person actually resides.

Source and reference attributes

Submitting organisation:

Standards Australia

Origin:

National Health Data Committee

National Community Services Data Committee

Reference documents:

AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia

AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Australia Post Postcode book. Reference through:

http://www1.auspost.com.au/postcodes/

Relational attributes

Related metadata references:

Supersedes Person (address)—Australian postcode (Postcode datafile), code NNN[N] NHIG, Superseded 04/05/2005, NCSIMG, Superseded 25/08/2005

See also Person—Australian state/territory identifier, code N NHIG, Standard 04/05/2005, NCSIMG, Standard 25/08/2005, NHDAMG, Standard 10/02/2006

Is used in the formation of Person—geographic location, community services code (ASGC 2004) NNNNN NCSIMG, Superseded 02/05/2006

Is used in the formation of Dwelling—geographic location, remoteness structure code (ASGC 2004) N[N] NHDAMG, Retired 10/02/2006

Implementation in Data Set Specifications:

Cardiovascular disease (clinical) DSS NHIG, Superseded 15/02/2006

Cardiovascular disease (clinical) DSS NHIG, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS NHIG, Standard 04/07/2007

Information specific to this data set:

The postcode can also be used in association with the Australian Bureau of Statistics Socio-Economic Indexes for Areas (SEIFA) index (Australian Bureau of Statistics Socio-Economic Indexes for Areas (SEIFA), Australia (CD-ROM) to derive socio-economic disadvantage, which is associated with cardiovascular risk.

People from lower socio-economic groups are more likely

to die from cardiovascular disease than those from higher socio-economic groups. In 1997, people aged 25 - 64 living in the most disadvantaged group of the population died from cardiovascular disease at around twice the rate of those living in the least disadvantaged group (Australian Institute of Health and Welfare (AIHW) 2001. Heart, stroke and vascular diseases- Australian facts 2001.).

This difference in death rates has existed since at least the 1970s.

Computer Assisted Telephone Interview demographic module DSS NHIG, Standard 04/05/2005

Information specific to this data set:

For data collection using Computer Assisted Telephone Interviewing (CATI) the suggested question is:

What is your postcode?

(Single response)

Enter Postcode

Health care client identification DSS NHIG, Standard 04/05/2005

Health care provider identification DSS NHIG, Superseded 04/07/2007

Health care provider identification DSS NHIG, Standard 04/07/2007

Postcode—Australian (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—Australian postcode, code (Postcode datafile) {NNNN}
METeOR identifier:	290064
Registration status:	NHIG, Standard 04/05/2005 NCSIMG, Standard 31/08/2005
Definition:	The numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of an organisation, as represented by a code.

Data element concept attributes

Data element concept:	Service provider organisation (address)—Australian postcode
Definition:	The numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of an organisation.
Context:	Postcode is an important part of an organisation's postal address and facilitates written communication. It is one of a number of geographic identifiers that can be used to determine a geographic location. Postcode may assist with uniquely identifying an organisation.
Object class:	Service provider organisation
Property:	Australian postcode

Value domain attributes

Representational attributes

Classification scheme:	Postcode datafile
Representation class:	Code
Data type:	Number
Format:	{NNNN}
Maximum character length:	4

Collection and usage attributes

Comments:	Postcode - Australian may be used in the analysis of data on a geographical basis, which involves a conversion from postcodes to the Australian Bureau of Statistics (ABS) postal areas. This conversion results in some inaccuracy of information. However, in some data sets postcode is the only geographic identifier, therefore the use of other more accurate indicators (e.g. Statistical Local Area (SLA)) is not always possible. When dealing with aggregate data, postal areas, converted from postcodes, can be mapped to Australian Standard Geographical Classification codes using an ABS concordance, for example to determine SLAs. It should be noted that such concordances should not be used to determine the SLA of any individual's postcode. Where individual street addresses are available, these can be mapped to ASGC codes (e.g. SLAs) using the ABS National Localities Index (NLI).

Data element attributes

Collection and usage attributes

Collection methods:	May be collected as part of Address line or separately. Postal addresses may be different from where a service is actually located.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	National Health Data Committee National Community Services Data Committee Australia Post Postcode book. Reference through: http://www1.auspost.com.au/postcodes/
Reference documents:	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Implementation in Data Set Specifications:	Health care provider identification DSS NHIG, Superseded 04/07/2007 Health care provider identification DSS NHIG, Standard 04/07/2007

Postcode—international (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—international postcode, text [X(10)]
METeOR identifier:	288985
Registration status:	NHIG, Standard 04/05/2005 NCSIMG, Standard 30/09/2005
Definition:	The code for a postal delivery area, aligned with locality, suburb or place for the address of a person, as defined by the postal service of a country other than Australia, as represented by text.

Data element concept attributes

Data element concept:	Person (address)—international postcode
Definition:	The code for a postal delivery area, aligned with locality, suburb or place for the address of a person, as defined by the postal service of a country other than Australia.
Object class:	Person
Property:	International postcode

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(10)]
Maximum character length:	10

Data element attributes

Collection and usage attributes

Collection methods:	This is a self-reported code from a person and may be non-verifiable without reference to the specific country's coding rules. May be collected as part of Address or separately. Postal addresses may be different from where a person actually resides.

Source and reference attributes

Submitting organisation:	Standards Australia

Relational attributes

Implementation in Data Set Specifications:	Health care client identification DSS NHIG, Standard 04/05/2005 Health care provider identification DSS NHIG, Superseded 04/07/2007 Health care provider identification DSS NHIG, Standard 04/07/2007

Postcode—international (service provider organisation)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Service provider organisation (address)—international postcode, text [X(10)]
METeOR identifier:	288987
Registration status:	NHIG, Standard 04/05/2005 NCSIMG, Standard 30/09/2005
Definition:	The code for a postal delivery area, aligned with locality, suburb or place for the address of an organisation, as defined by the postal service of a country other than Australia.

Data element concept attributes

Data element concept:	Service provider organisation (address)—international postcode
Definition:	The code for a postal delivery area, aligned with locality, suburb or place for the address of an organisation, as defined by the postal service of a country other than Australia.
Object class:	Service provider organisation
Property:	International postcode

Source and reference attributes

Submitting organisation:	Standards Australia

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(10)]
Maximum character length:	10

Data element attributes

Collection and usage attributes

Collection methods:	This is a self-reported code from an organisation and may be non-verifiable without reference to the specific country's coding rules. May be collected as part of Address or separately. Postal addresses may be different from where a service is actually located.

Source and reference attributes

Submitting organisation:	Standards Australia

Relational attributes

Implementation in Data Set Specifications:	Health care provider identification DSS NHIG, Superseded 04/07/2007

Postpartum complication

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—complication (postpartum), code (ICD-10-AM 5th edn) ANN{.N[N]}
METeOR identifier:	333810
Registration status:	NHIG, Standard 07/12/2005
Definition:	Medical and obstetric complications of the mother occurring during the postnatal period up to the time of separation from care, as represented by a code.

Data element concept attributes

Data element concept:	Birth event—complication (postpartum)
Definition:	Medical and obstetric complications of the mother occurring during the postnatal period up to the time of separation from care.
Context:	Perinatal statistics
Object class:	Birth event
Property:	Complication

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 5th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Collection and usage attributes

Guide for use:	Complications and conditions should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM.

Data element attributes

Collection and usage attributes

Guide for use:	There is no arbitrary limit on the number of conditions specified.
Comments:	Examples of such conditions include postpartum haemorrhage, retained placenta, puerperal infections, puerperal psychosis, essential hypertension, psychiatric disorders, diabetes mellitus, epilepsy, cardiac disease and chronic renal disease. Complications of the puerperal period may cause maternal morbidity, and occasionally death, and may be an important factor in prolonging the duration of hospitalisation after

childbirth.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Origin: International Classification of Diseases - 10th Revision, Australian Modification (5th Edition 2005) National Centre for Classification in Health, Sydney.

Relational attributes

Related metadata references: Supersedes Birth event—complication (postpartum), code (ICD-10-AM 4th edn) ANN{.N[N]} NHIG, Superseded 07/12/2005

Preferred language

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—preferred language, code (ASCL 2005) NN{NN}
METeOR identifier:	304128
Registration status:	NHIG, Standard 08/02/2006 NCSIMG, Standard 29/04/2006
Definition:	The language (including sign language) most preferred by the person for communication, as represented by a code.

Data element concept attributes

Data element concept:	Person—preferred language
Definition:	The language (including sign language) most preferred by the person for communication.
Context:	Health and welfare services: An important indicator of ethnicity, especially for persons born in non-English-speaking countries. Its collection will assist in the planning and provision of multilingual services and facilitate program and service delivery for migrants and other non-English speakers.
Object class:	Person
Property:	Preferred language

Value domain attributes

Representational attributes

Classification scheme:	Australian Standard Classification of Languages 2005
Representation class:	Code
Data type:	Number
Format:	NN{NN}
Maximum character length:	4

Collection and usage attributes

Guide for use:	The Australian Standard Classification of Languages (ASCL) has a three- level hierarchical structure. The most detailed level of the classification consists of base units (languages) which are represented by four-digit codes. The second level of the classification comprises narrow groups of languages (the Narrow Group level), identified by the first two digits. The most general level of the classification consists of broad groups of languages (the Broad Group level) and is identified by the first digit. The classification includes Australian Indigenous languages and sign languages. For example, the Lithuanian language has a code of 3102. In this case 3 denotes that it is an Eastern European language, while 31 denotes that it is a Baltic language. The Pintupi Aboriginal language is coded as 8713. In this case 8 denotes that it is an Australian Indigenous language and 87 denotes that the language is Western Desert language.

Language data may be output at the Broad Group level, Narrow Group level or base level of the classification. If necessary significant Languages within a Narrow Group can be presented separately while the remaining Languages in the Narrow Group are aggregated. The same principle can be adopted to highlight significant Narrow Groups within a Broad Group.

Data element attributes

Collection and usage attributes

Guide for use: This may be a language other than English even where the person can speak fluent English.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: ABS cat. no.1267.0.Australian Standard Classification of Languages (ASCL), 2005-06. Canberra: Australian Bureau of Statistics

Relational attributes

Related metadata references: Supersedes Person—preferred language, code NN NHIG, Superseded 08/02/2006

Implementation in Data Set Specifications: Alcohol and other drug treatment services NMDS NHIG, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 NHIG, Standard 23/10/2006

Implementation start date: 01/07/2007

Cardiovascular disease (clinical) DSS NHIG, Superseded 04/07/2007

Cardiovascular disease (clinical) DSS NHIG, Standard 04/07/2007

Pregnancy—current status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female— pregnancy indicator (current), code N
METeOR identifier:	302817
Registration status:	NHIG, Standard 21/09/2005
Definition:	Whether the female person is currently pregnant, as represented by a code.

Data element concept attributes

Data element concept:	Female— pregnancy indicator
Definition:	Whether or not a female person is pregnant.
Context:	Public health, health care and clinical settings.
Object class:	Female
Property:	Pregnancy indicator

Source and reference attributes

Submitting organisation:	National Diabetes Data Working Group

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Yes
	2	No
Supplementary values:	9	Not stated/inadequately described

Collection and usage attributes

Guide for use:	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:	CODE 1 Yes: Record if the female individual currently pregnant. CODE 2 No: Record if the female individual not currently pregnant.
Collection methods:	Ask the individual if she is currently pregnant.

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 Female—current pregnancy status, code N NHIG, Superseded 21/09/2005

Implementation in Data Set Specifications: Diabetes (clinical) DSS NHIG, Standard 21/09/2005

Information specific to this data set:

Pregnancy in women with pre-existing diabetes is a potentially serious problem for both the mother and fetus. Good metabolic control and appropriate medical and obstetric management will improve maternal and fetal outcomes. The diagnosis or discovery of diabetes in pregnancy (gestational diabetes), identifies an at risk pregnancy from the fetal perspective, and identifies the mother as at risk for the development of type 2 diabetes later in life.

Following Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus diabetes management during pregnancy includes:

- routine medical review every 2-3 weeks during the first 30 weeks and then every 1-2 weeks until delivery
- monitor HbA1c every 4-6 weeks or more frequently if indicated to ensure optimal metabolic control during pregnancy
- advise patients to monitor blood glucose frequently and urinary ketones
- initial assessment and on going monitoring for signs or progression of diabetes complications
- regular routine obstetric review based on the usual indicators.

Management targets

- Blood glucose levels:

  Fasting Post-prandial
- HbA1c levels within normal range for pregnancy. (The reference range for HbA1c will be lower during pregnancy).
- The absence of any serious or sustained ketonuria.

Normal indices for fetal and maternal welfare. Oral hypoglycaemic agents are contra-indicated during pregnancy and therefore women with pre-existing diabetes who are treated with oral agents should ideally be converted to insulin prior to conception.

What to do if unsatisfactory metabolic control:

- explore reasons for unsatisfactory control such as diet, intercurrent illness, appropriateness of medication, concurrent medication, stress, and exercise, and review management,
- review and adjust treatment,
- consider referral to diabetes educator, dietician, endocrinologist or physician experienced in diabetes care, or diabetes centre.

Premature cardiovascular disease family history (status)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—premature cardiovascular disease family history status, code N
METeOR identifier:	270280
Registration status:	NHIG, Standard 01/03/2005
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 attributes

Data element concept:	Person—premature cardiovascular disease family history status
Definition:	Identifies a person who has a first degree relative (father, mother or sibling) who has had a vascular event or condition diagnosed before the age of 60 years.
Context:	Public health, health care and clinical settings.
Object class:	Person
Property:	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:

Value	Meaning
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 Premature cardiovascular disease family history - status, version 1, DE, NHDD, NHIMG, Superseded 01 / 03 / 2005

Implementation in Data Set Specifications:

Acute coronary syndrome (clinical) DSS NHIG, Standard 07 / 12 / 2005

Acute coronary syndrome (clinical) DSS NHIG, Superseded 07 / 12 / 2005

Cardiovascular disease (clinical) DSS NHIG, Superseded 15 / 02 / 2006

Cardiovascular disease (clinical) DSS NHIG, Superseded 04 / 07 / 2007

Cardiovascular disease (clinical) DSS NHIG, Standard 04 / 07 / 2007

Information specific to this data set:
Having a family history of cardiovascular disease (CVD) is a risk factor for CVD and the risk increases if the event in the family member occurs at a young age. For vascular risk assessment a premature family history is considered to be present where a first-degree relative under age 60 years (woman or man) has had a vascular event / condition diagnosed. The evidence of family history being a strong risk factor for stroke only applies to certain limited stroke subtypes in certain populations.

Presentation at birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—birth presentation, code N
METeOR identifier:	299992
Registration status:	NHIG, Standard 06/09/2006
Definition:	The presenting part of the fetus at birth, as represented by a code.

Data element concept attributes

Data element concept:	Birth event—birth presentation
Definition:	Presenting part of the fetus at birth.
Context:	Perinatal statistics: Presentation types other than vertex are associated with higher rates of caesarean section, instrumental delivery, perinatal mortality and neonatal morbidity.
Object class:	Birth event
Property:	Birth presentation

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Vertex
2	Breech
3	Face
4	Brow
8	Other

Supplementary values:

9	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Data element attributes

Collection and usage attributes

Guide for use:	Compound presentations (where an extremity prolapses simultaneously alongside the presenting part) should be coded to '8 Other'.

	All other malpresentations, including for example, cord, shoulder or hand, should be coded to '8 Other'.
Collection methods:	In the case of multiple births, presentation should be recorded for each baby born.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Birth event—birth presentation, code N NHIG, Superseded 06/09/2006
Implementation in Data Set Specifications:	Perinatal NMDS 2007-2008 NHIG, Standard 06/09/2006 *Implementation start date:* 01/07/2007

Previous pregnancies—ectopic

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—number of previous pregnancies (ectopic), total NN
METeOR identifier:	269936
Registration status:	NHIG, Standard 01/03/2005
Definition:	The total number of previous pregnancies of a female resulting in ectopic pregnancy.

Data element concept attributes

Data element concept:	Female—number of previous pregnancies
Definition:	The total number of previous pregnancies.
Object class:	Female
Property:	Number of previous pregnancies

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	String
Format:	N[N]
Maximum character length:	2

Supplementary values:

Value	Meaning
99	Not stated

Unit of measure: Pregnancy

Data element attributes

Collection and usage attributes

Guide for use:

A pregnancy resulting in multiple births should be counted as once pregnancy.

In multiple pregnancies with more than one type of outcome, the pregnancies should be recorded in the following order:

- all live births
- stillbirth
- spontaneous abortion
- induced abortion
- ectopic pregnancy

Where the outcome was one stillbirth and one live birth, count as stillbirth.

If a previous pregnancy was a hydatidiform mole, code as spontaneous or induced abortion (or rarely, ectopic pregnancy), depending on the outcome.

Comments:

The number of previous pregnancies is an important component of the woman's reproductive history. Parity may be a risk factor for adverse maternal and perinatal outcomes.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Previous pregnancies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Previous pregnancies—induced abortion

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—number of previous pregnancies (induced abortion), total NN
METeOR identifier:	269935
Registration status:	NHIG, Standard 01/03/2005
Definition:	The total number of previous pregnancies of a female resulting in induced abortion (termination of pregnancy before 20 weeks' gestation).

Data element concept attributes

Data element concept:	Female—number of previous pregnancies
Definition:	The total number of previous pregnancies.
Object class:	Female
Property:	Number of previous pregnancies

Value domain attributes

Representational attributes

Representation class:	Total	
Data type:	String	
Format:	N[N]	
Maximum character length:	2	
Supplementary values:	Value	Meaning
	99	Not stated
Unit of measure:	Pregnancy	

Data element attributes

Collection and usage attributes

Guide for use:

A pregnancy resulting in multiple births should be counted as once pregnancy.

In multiple pregnancies with more than one type of outcome, the pregnancies should be recorded in the following order:

- all live births
- stillbirth
- spontaneous abortion
- induced abortion
- ectopic pregnancy

Where the outcome was one stillbirth and one live birth, count as stillbirth.

If a previous pregnancy was a hydatidiform mole, code as spontaneous or induced abortion (or rarely, ectopic pregnancy), depending on the outcome.

Comments: The number of previous pregnancies is an important component of the woman's reproductive history. Parity may be a risk factor for adverse maternal and perinatal outcomes.

A previous history of induced abortion may increase the risk of some outcomes in subsequent pregnancies.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Previous pregnancies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Previous pregnancies—live birth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—number of previous pregnancies (live birth), total NN
METeOR identifier:	269931
Registration status:	NHIG, Standard 01/03/2005
Definition:	The total number of previous pregnancies of a female resulting in **live birth**.

Data element concept attributes

Data element concept:	Female—number of previous pregnancies
Definition:	The total number of previous pregnancies.
Object class:	Female
Property:	Number of previous pregnancies

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	String
Format:	N[N]
Maximum character length:	2

Supplementary values:

Value	Meaning
99	Not stated

Unit of measure: Pregnancy

Data element attributes

Collection and usage attributes

Guide for use:

A pregnancy resulting in multiple births should be counted as once pregnancy.

In multiple pregnancies with more than one type of outcome, the pregnancies should be recorded in the following order:

- all live births
- stillbirth
- spontaneous abortion
- induced abortion
- ectopic pregnancy

Where the outcome was one stillbirth and one live birth, count as stillbirth.

If a previous pregnancy was a hydatidiform mole, code as spontaneous or induced abortion (or rarely, ectopic pregnancy), depending on the outcome.

Comments:

The number of previous pregnancies is an important component of the woman's reproductive history. Parity may be a risk factor for adverse maternal and perinatal outcomes.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Previous pregnancies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Previous pregnancies—spontaneous abortion

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—number of previous pregnancies (spontaneous abortion), total NN
METeOR identifier:	269934
Registration status:	NHIG, Standard 01/03/2005
Definition:	The total number of previous pregnancies of a female resulting in spontaneous abortion (less than 20 weeks' gestational age, or less than 400 g **birthweight** if gestational age is unknown).

Data element concept attributes

Data element concept:	Female—number of previous pregnancies
Definition:	The total number of previous pregnancies.
Object class:	Female
Property:	Number of previous pregnancies

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	String
Format:	N[N]
Maximum character length:	2

Supplementary values:

Value	Meaning
99	Not stated

Unit of measure: Pregnancy

Data element attributes

Collection and usage attributes

Guide for use:

A pregnancy resulting in multiple births should be counted as once pregnancy.

In multiple pregnancies with more than one type of outcome, the pregnancies should be recorded in the following order:

- all live births
- stillbirth
- spontaneous abortion
- induced abortion
- ectopic pregnancy

Where the outcome was one stillbirth and one live birth, count as stillbirth.

If a previous pregnancy was a hydatidiform mole, code as spontaneous or induced abortion (or rarely, ectopic pregnancy), depending on the outcome.

Comments: The number of previous pregnancies is an important component of the woman's reproductive history. Parity may be a risk factor for adverse maternal and perinatal outcomes.

A previous history of spontaneous abortion identifies the mother as high risk for subsequent pregnancies.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Previous pregnancies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Previous pregnancies—stillbirth

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female—number of previous pregnancies (stillbirth), total N[N]
METeOR identifier:	269933
Registration status:	NHIG, Standard 01/03/2005
Definition:	The total number of previous pregnancies of a female resulting in stillbirth (- at least 20 weeks' gestational age or 400 g **birthweight**).

Data element concept attributes

Data element concept:	Female—number of previous pregnancies
Definition:	The total number of previous pregnancies.
Object class:	Female
Property:	Number of previous pregnancies

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	String
Format:	N[N]
Maximum character length:	2

Supplementary values:

Value	Meaning
99	Not stated

Unit of measure: Pregnancy

Data element attributes

Collection and usage attributes

Guide for use:

A pregnancy resulting in multiple births should be counted as once pregnancy.

In multiple pregnancies with more than one type of outcome, the pregnancies should be recorded in the following order:

- all live births
- stillbirth
- spontaneous abortion
- induced abortion
- ectopic pregnancy

Where the outcome was one stillbirth and one live birth, count as stillbirth.

If a previous pregnancy was a hydatidiform mole, code as spontaneous or induced abortion (or rarely, ectopic pregnancy), depending on the outcome.

Comments:

The number of previous pregnancies is an important component of the woman's reproductive history. Parity may be

a risk factor for adverse maternal and perinatal outcomes.

A previous history of stillbirth identifies the mother as high risk for subsequent pregnancies.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes Previous pregnancies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Previous specialised treatment

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—previous specialised treatment, code N
METeOR identifier:	270374
Registration status:	NHIG, Standard 01/03/2005
Definition:	Whether a patient has had a previous **admission** or service contact for treatment in the specialty area within which treatment is now being provided, as represented by a code.

Data element concept attributes

Data element concept:	Patient—previous specialised treatment
Definition:	Whether a patient has had a previous **admission** or service contact for treatment in the specialty area within which treatment is now being provided.
Object class:	Patient
Property:	Previous specialised treatment

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Patient has no previous admission(s) or service contact(s) for the specialised treatment now being provided
2	Patient has previous hospital admission(s) but no service contact(s) for the specialised treatment now being provided
3	Patient has previous service contact(s) but no hospital admission(s) for the specialised treatment now being provided
4	Patient has both previous hospital admission(s) and service contact(s) for the specialised treatment now being provided

Supplementary values:

Value	Meaning
5	Unknown/not stated

Collection and usage attributes

Guide for use:

CODE 1 Patient has no previous admission(s) or service contact(s) for the specialised treatment now being provided

Use this code for admitted patients, whose only prior specialised treatment contact was the service contact that referred the patient for admission.

CODES 2-4 These codes include patients who have been seen at any time in the past within the speciality within which the

patient is currently being treated (mental health or palliative care), regardless of whether it was part of the current episode or a previous admission / service contact many years in the past. Use these codes regardless of whether the previous treatment was provided within the service in which the person is now being treated, or another equivalent specialised service (either institutional or community-based).

CODE 2 Patient has previous hospital admission(s) but no service contact(s) for the specialised treatment now being provided

CODE 3 Patient has previous service contact(s) but no hospital admission(s) for the specialised treatment now being provided

CODE 4 Patient has both previous hospital admission(s) and service contact(s) for the specialised treatment now being provided

Data element attributes

Collection and usage attributes

Comments: This metadata item was originally developed in the context of mental health institutional care data development (originally metadata item Problem status and later First admission for psychiatric treatment). More recent data development work, particularly in the area of palliative care, led to the need for this item to be re-worded in more generic terms for inclusion in other data sets.

For palliative care, the value of this data element is in its use in enabling approximate identification of the number of new palliative care patients receiving specialised treatment. The use of this data element in this way would be improved by the reporting of this data by community-based services.

Source and reference attributes

Submitting organisation: National Mental Health Information Strategy Committee

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Previous specialised treatment, version 3, DE, NHDD, NHIMG, Superseded 01 / 03 / 2005

Implementation in Data Set Specifications: Admitted patient mental health care NMDS NHIG, Superseded 07 / 12 / 2005

Implementation start date: 01 / 07 / 2005

Implementation end date: 30 / 06 / 2006

Admitted patient mental health care NMDS NHIG, Superseded 23 / 10 / 2006

Implementation start date: 01 / 07 / 2006

Implementation end date: 30 / 06 / 2007

Admitted patient mental health care NMDS 2007-2008 NHIG, Standard 23 / 10 / 2006

Implementation start date: 01 / 07 / 2007

Admitted patient palliative care NMDS NHIG, Superseded

07 / 12 / 2005

Implementation start date: 01 / 07 / 2005

Implementation end date: 30 / 06 / 2006

Admitted patient palliative care NMDS 2006-2007 NHIG, Superseded 23 / 10 / 2006

Implementation start date: 01 / 07 / 2006

Implementation end date: 30 / 06 / 2007

Admitted patient palliative care NMDS 2007-08 NHIG, Standard 23 / 10 / 2006

Implementation start date: 01 / 07 / 2007

Information specific to this data set:
For palliative care, the value of this item is in its use in enabling approximate identification of the number of new palliative care patients receiving specialised treatment. The use of this metadata item in this way would be improved by the reporting of this data by community-based services.

Primary site of cancer (ICD-10-AM code)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—primary site of cancer, code (ICD-10-AM 5th edn) ANN{.N[N]}
METeOR identifier:	333927
Registration status:	NHIG, Standard 07/12/2005
Definition:	The site of origin of the tumour, as opposed to the secondary or metastatic sites, as represented by an ICD-10-AM code.

Data element concept attributes

Data element concept:	Person with cancer—primary site of cancer
Definition:	The primary site is the site of origin of the tumour, as opposed to the secondary or metastatic sites. It is described by reporting the anatomical position (topography) of the tumour.
Object class:	Person with cancer
Property:	Primary site of cancer

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 5th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Collection and usage attributes

Guide for use:	Report the primary site of cancer, if known, for patients who have been diagnosed with a cancer. In ICD-10-AM (5th edition), primary site is identified using a single 4 digit code Cxx.x or Dxx.x.

Source and reference attributes

Reference documents:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10)

Data element attributes

Collection and usage attributes

Collection methods:	In a hospital setting, primary site of cancer should be recorded on the patient's medical record by the patient's attending clinician or medical practitioner, and coded by the hospital's medical records department. Hospitals use Diagnosis codes from ICD-10-AM (5th edition). Valid codes must start with C or D.

In hospital reporting, the diagnosis code for each separate primary site cancer will be reported as a Principal diagnosis or an Additional diagnosis as defined in the current edition of the Australian Coding Standards. In death reporting, the Australian Bureau of Statistics uses ICD-10.

Some ICD-10-AM (5th edition) diagnosis codes e.g. mesothelioma and Kaposi's sarcoma, are based on morphology and not site alone, and include tumours of these types even where the primary site is unknown.

Source and reference attributes

Origin: World Health Organization

Relational attributes

Related metadata references: Supersedes Person with cancer—primary site of cancer, code (ICD-10-AM 4th edn) ANN{.N[N]} NHIG, Superseded 07/12/2005

Implementation in Data Set Specifications: Cancer (clinical) DSS NHIG, Standard 07/12/2005

Information specific to this data set:
This information is collected for the purpose of:

- classifying tumours into clinically-relevant groupings on the basis of both their site of origin and their histological type
- monitoring the number of new cases of cancer for planning treatment services
- epidemiological studies.

Primary site of cancer (ICDO-3 code)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—primary site of cancer, code (ICDO-3) ANN{.N[N]}
METeOR identifier:	270178
Registration status:	NHIG, Standard 01/03/2005
Definition:	The site of origin of the tumour, as opposed to the secondary or metastatic sites, as represented by an ICDO-3 code.

Data element concept attributes

Data element concept:	Person with cancer—primary site of cancer
Definition:	The primary site is the site of origin of the tumour, as opposed to the secondary or metastatic sites. It is described by reporting the anatomical position (topography) of the tumour.
Object class:	Person with cancer
Property:	Primary site of cancer

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Diseases for Oncology 3rd edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Collection and usage attributes

Guide for use:

Report the primary site of cancer, if known, for patients who have been diagnosed with a cancer.

In ICDO, primary site is identified using both the Cxx.x code identifying site and the behaviour code to identify whether the site is the primary site. The behaviour code numbers used in ICDO are listed below:

0 Benign

1 Uncertain whether benign or malignant

- borderline malignancy
- low malignant potential

2 Carcinoma in situ

- intraepithelial
- non-infiltrating
- non-invasive

3 Malignant, primary site

6 Malignant, metastatic site

- malignant, secondary site

9 Malignant, uncertain whether primary or metastatic site

Data element attributes

Collection and usage attributes

Collection methods: Cancer registries use Site codes from ICDO 3rd edition.

Source and reference attributes

Origin: World Health Organization

Relational attributes

Related metadata references: Supersedes Primary site of cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Implementation in Data Set Specifications: Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Cancer (clinical) DSS NHIG, Standard 07/12/2005

Information specific to this data set:
This information is collected for the purpose of:

- classifying tumours into clinically-relevant groupings on the basis of both their site of origin and their histological type
- monitoring the number of new cases of cancer for planning treatment services
- epidemiological studies.

Principal area of clinical practice

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health professional—area of clinical practice (principal), code ANN
METeOR identifier:	270144
Registration status:	NHIG, Standard 01/03/2005
Definition:	Principal area of clinical practice is defined as either the field of principal professional clinical activity or the primary area of responsibility, depending on the profession, as represented by a code.

Data element concept attributes

Data element concept:	Health professional—area of clinical practice (principal)
Definition:	Principal area of clinical practice is defined as either the field of principal professional clinical activity or the primary area of responsibility, depending on the profession. It may be described in terms of the particular discipline, skills or knowledge field of the profession, whether general or specialised; or described in terms of the principal client group; or described by the principal activity of an institution, or section of an institution, where clinical practice takes place.
Context:	Health labour force
Object class:	Health professional
Property:	Area of clinical practice

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	ANN
Maximum character length:	3

Permissible values:

Value	Meaning
A11	General Practitioner (GP)/primary medical care practitioner - general practice
A12	GP/primary medical care practitioner - a special interest area (specified)
A21	GP/primary medical care practitioner - vocationally registered
A22	GP/primary medical care practitioner - holder of fellowship of Royal Australian College of General Practitioners (RACGP)
A23	GP/primary medical care practitioner - RACGP trainee
A24	GP/primary medical care practitioner - other
B31	Non-specialist hospital (salaried) - Resident

	Medical Officer (RMO) / intern
B32	Non-specialist hospital (salaried) - other hospital career
B41	Non-specialist hospital (salaried) - holder of Certificate of Satisfactory Completion of Training
B42	Non-specialist hospital (salaried) - RACGP trainee
B44	Non-specialist hospital (salaried) - other
B51	Non-specialist hospital (salaried) - specialist (includes private and hospital)
B52	Non-specialist hospital (salaried) - specialist in training (e.g. registrar)
B90	Non-specialist hospital (salaried) - not applicable
C01	Nurse labour force - mixed medical / surgical nursing
C02	Nurse labour force - medical nursing
C03	Nurse labour force - surgical nursing
C04	Nurse labour force - operating theatre nursing
C05	Nurse labour force - intensive care nursing
C06	Nurse labour force - paediatric nursing
C07	Nurse labour force - maternity and obstetric nursing
C08	Nurse labour force - psychiatric / mental health nursing
C09	Nurse labour force - developmental disability nursing
C10	Nurse labour force - gerontology / geriatric nursing
C11	Nurse labour force - accident and emergency nursing
C12	Nurse labour force - community health nursing
C13	Nurse labour force - child health nursing
C14	Nurse labour force - school nursing
C15	Nurse labour force - district / domiciliary nursing
C16	Nurse labour force - occupational health nursing
C17	Nurse labour force - private medical practice nursing
C18	Nurse labour force - independent practice
C19	Nurse labour force - independent midwifery practice
C20	Nurse labour force - no one principal area of practice
C98	Nurse labour force - other (specify)
C99	Nurse labour force - unknown / inadequately described / not stated

Data element attributes

Collection and usage attributes

Guide for use:

Specifics will vary for each profession as appropriate and will be reflected in the classification / coding that is applied. Classification within the National Health Labour Force Collection is profession-specific.

Comments:

The nursing labour force-specific codes are subject to revision because of changes in the profession and should be read in the context of the comments below.

It is strongly recommended that, in the case of the nurse labour force, further disaggregation be avoided as much as possible. The reason for this recommendation is that any expansion of the classification to include specific specialty areas (e.g. cardiology, otorhinolaryngology, gynaecology etc.) will only capture data from hospitals with dedicated wards or units; persons whose clinical practice includes a mix of cases within a single ward setting (as in the majority of country and minor metropolitan hospitals) will not be included in any single specialty count, leading to a risk of the data being misinterpreted. The data would show a far lower number of practitioners involved in providing services to patients with some of the listed specialty conditions than is the case.

Source and reference attributes

Submitting organisation:

National Health Labour Force Data Working Group

Relational attributes

Related metadata references:

Supersedes Principal area of clinical practice, version 1, DE, NHDD, NHIMG, Superseded 01 / 03 / 2005

Implementation in Data Set Specifications:

Health labour force NMDS NHIG, Standard 01 / 03 / 2005

Implementation start date: 01 / 07 / 2005

Information specific to this data set:
To analyse distribution of clinical service providers by the area of their principal clinical practice. Cross-classified with other data, this metadata item allows analysis of geographic distribution and profiles of population subsets. Required for health labour force modelling.

Principal diagnosis

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—principal diagnosis, code (ICD-10-AM 5th edn) ANN{.N[N]}
METeOR identifier:	333838
Registration status:	NHIG, Standard 07/12/2005
Definition:	The diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care, an episode of residential care or an attendance at the health care establishment, as represented by a code.

Data element concept attributes

Data element concept:	Episode of care—principal diagnosis
Definition:	The diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care, an episode of residential care or an attendance at the health care establishment.
Context:	Health services
Object class:	Episode of care
Property:	Principal diagnosis

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 5th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:	The principal diagnosis must be determined in accordance with the Australian Coding Standards. Each episode of admitted patient care must have a principal diagnosis and may have additional diagnoses. The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status. As a minimum requirement the Principal diagnosis code must be a valid code from the current edition of ICD-10-AM. For episodes of admitted patient care, some diagnosis codes are too imprecise or inappropriate to be acceptable as a principal diagnosis and will group to 951Z, 955Z and 956Z in the Australian Refined Diagnosis Related Groups.

Diagnosis codes starting with a V, W, X or Y, describing the circumstances that cause an injury, rather than the nature of the injury, cannot be used as principal diagnosis. Diagnosis codes which are morphology codes cannot be used as principal diagnosis.

Collection methods: A principal diagnosis should be recorded and coded upon **separation**, for each episode of patient care. The principal diagnosis is derived from and must be substantiated by clinical documentation.

Comments: The principal diagnosis is one of the most valuable health data elements. It is used for epidemiological research, casemix studies and planning purposes.

Source and reference attributes

Origin: Health Data Standards Committee

National Centre for Classification in Health

National Data Standard for Injury Surveillance Advisory Group

Reference documents: Bramley M, Peasley K, Langtree L and Innes K 2002. The ICD-10-AM Mental Health Manual: an integrated classification and diagnostic tool for community-based mental health services. Sydney: National Centre for Classification in Health, University of Sydney

Relational attributes

Related metadata references: Supersedes Episode of care—principal diagnosis, code (ICD-10-AM 4th edn) ANN{.N[N]} NHIG, Superseded 07/12/2005

Implementation in Data Set Specifications: Admitted patient care NMDS 2006-2007 NHIG, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006

Implementation start date: 01/07/2007

Information specific to this data set:
The principal diagnosis is a major determinant in the classification of Australian Refined Diagnosis Related Groups and Major Diagnostic Categories.

Where the principal diagnosis is recorded prior to discharge (as in the annual census of public psychiatric hospital patients), it is the current provisional principal diagnosis. Only use the admission diagnosis when no other diagnostic information is available. The current provisional diagnosis may be the same as the admission diagnosis.

Effective for collection from 01/07/2006

Admitted patient mental health care NMDS NHIG, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Information specific to this data set:
Effective for collection from 01/07/2006

Admitted patient mental health care NMDS 2007-2008 NHIG,

Standard 23/10/2006

Implementation start date: 01/07/2007

Admitted patient palliative care NMDS 2006-2007 NHIG, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient palliative care NMDS 2007-08 NHIG, Standard 23/10/2006

Implementation start date: 01/07/2007

Community mental health care NMDS 2006-2007 NHIG, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Community mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

Implementation start date: 01/07/2007

Information specific to this data set:
Codes can be used from ICD-10-AM or from The ICD-10-AM Mental Health Manual: An Integrated Classification and Diagnostic Tool for Community-Based Mental Health Services, published by the National Centre for Classification in Health 2002.

Effective for collection from 01/07/2006

Residential mental health care NMDS 2006-2007 NHIG, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Residential mental health care NMDS 2007-2008 NHIG, Standard 23/10/2006

Implementation start date: 01/07/2007

Information specific to this data set:
Codes can be used from ICD-10-AM or from The ICD-10-AM Mental Health Manual: An Integrated Classification and Diagnostic Tool for Community-Based Mental Health Services, published by the National Centre for Classification in Health 2002.

The principal diagnosis should be recorded and coded upon the end of an episode of residential care (i.e. annually for continuing residential care).

Effective for collection form 01/07/2006

Principal drug of concern

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of treatment for alcohol and other drugs—drug of concern (principal), code (ASCDC 2000 extended) NNNN
METeOR identifier:	270109
Registration status:	NHIG, Standard 01/03/2005
Definition:	The main drug, as stated by the client, that has led a person to seek treatment from the service, as represented by a code.
Context:	Required as an indicator of the client's treatment needs.

Data element concept attributes

Data element concept:	Episode of treatment for alcohol and other drugs—drug of concern
Definition:	The drug of concern during an episode of treatment for alcohol and other drugs.
Context:	Alcohol and other drug treatment services.
Object class:	Episode of treatment for alcohol and other drugs
Property:	Drug of concern

Value domain attributes

Representational attributes

Classification scheme:	Australian Standard Classification of Drugs of Concern 2000
Representation class:	Code
Data type:	String
Format:	NNNN
Maximum character length:	4

Supplementary values:

Value	Meaning
0005	Opioid analgesics not further defined
0006	Psychostimulants not further defined

Collection and usage attributes

Guide for use:

The Australian Standard Classification of Drugs of Concern (ASCDC) provides a number of supplementary codes that have specific uses and these are detailed within the ASCDC e.g. 0000 = inadequately described.

Other supplementary codes that are not already specified in the ASCDC may be used in National Minimum Data Sets (NMDS) when required. In the Alcohol and other drug treatment service NMDS, two additional supplementary codes have been created which enable a finer level of detail to be captured:

CODE 0005 Opioid analgesics not further defined

This code is to be used when it is known that the client's principal drug of concern is an opioid but the specific opioid used is not known. The existing code 1000 combines opioid analgesics and non-opioid analgesics together into Analgesics

nfd and the finer level of detail, although known, is lost.

CODE 0006 Psychostimulants not further defined

This code is to be used when it is known that the client's principal drug of concern is a psychostimulant but not which type. The existing code 3000 combines stimulants and hallucinogens together into Stimulants and hallucinogens nfd and the finer level of detail, although known, is lost.

Psychostimulants refer to the types of drugs that would normally be coded to 3100-3199, 3300-3399 and 3400-3499 categories plus 3903 and 3905.

Data element attributes

Collection and usage attributes

Guide for use: The principal drug of concern should be the main drug of concern to the client and is the focus of the client's treatment episode. If the client has been referred into treatment and does not nominate a drug of concern, then the drug involved in the client's referral should be chosen.

Collection methods: To be collected on commencement of the treatment episode.

For clients whose treatment episode is related to the alcohol and other drug use of another person, this metadata item should not be collected.

Source and reference attributes

Submitting organisation: Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references: Supersedes Principal drug of concern, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005

Implementation in Data Set Specifications: Alcohol and other drug treatment services NMDS NHIG, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

Alcohol and other drug treatment services NMDS NHIG, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Alcohol and other drug treatment services NMDS 2007-2008 NHIG, Standard 23/10/2006

Implementation start date: 01/07/2007

Principal role of health professional

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health professional—principal role, code N
METeOR identifier:	270145
Registration status:	NHIG, Standard 01/03/2005
Definition:	The principal role in which the health professional usually works the most hours each week, as represented by a code.

Data element concept attributes

Data element concept:	Health professional—principal role
Definition:	The principal role of a health professional is that in which the person usually works the most hours each week.
Context:	Health labour force
Object class:	Health professional
Property:	Principal role

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Clinician
2	Administrator
3	Teacher/educator
4	Researcher
5	Public health/health promotion
6	Occupational health
7	Environmental health

Supplementary values:

9	Unknown/inadequately described/not stated

Collection and usage attributes

Guide for use:

CODE 1 Clinician

A clinician is a person mainly involved in the area of clinical practice, i.e. diagnosis, care and treatment, including recommended preventative action, to patients or clients. Clinical practice may involve direct client contact or may be practised indirectly through individual case material (as in radiology and laboratory medicine).

CODE 2 Administrator

An administrator in a health profession is a person whose main job is in an administrative capacity in the profession, e.g. directors of nursing, medical superintendents, medical advisors

in government health authorities, health profession union administrators (e.g. Australian Medical Association, Australian Nurses Federation).

CODE 3 Teacher / educator

A teacher / educator in a health profession is a person whose main job is employment by tertiary institutions or health institutions to provide education and training in the profession.

CODE 4 Researcher

A researcher in a health profession is a person whose main job is to conduct research in the field of the profession, especially in the area of clinical activity. Researchers are employed by tertiary institutions, medical research bodies, health institutions, health authorities, drug companies and other bodies.

CODES 5 - 7

CODE 5 Public health / health promotion

CODE 6 Occupational health

CODE 7 Environmental health

Public health / health promotion, occupational health and environmental health are specialties in medicine, and fields of practice for some other health professions. They are public health rather than clinical practice, and hence are excluded from clinical practice.

Data element attributes

Collection and usage attributes

Collection methods: For respondents indicating that their principal professional role is in clinical practice, a more detailed identification of that role is established according to profession-specific categories.

Source and reference attributes

Submitting organisation: National Health Labour Force Data Working Group

Relational attributes

Related metadata references: Supersedes Principal role of health professional, version 1, DE, NHDD, NHIMG, Superseded 01 / 03 / 2005

Implementation in Data Set Specifications: Health labour force NMDS NHIG, Standard 01 / 03 / 2005

Implementation start date: 01 / 07 / 2005

Information specific to this data set:
This metadata item provides information on the principal professional role of respondents who currently work within the broad context / discipline field of their profession (as determined by the metadata item Professional labour force status). Identification of clinicians provides comparability with other labour force collections that just include clinicians.

Procedure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—procedure, code (ACHI 5th edn) NNNNN-NN
METeOR identifier:	333828
Registration status:	NHIG, Standard 07/12/2005
Definition:	A clinical intervention represented by a code that: • is surgical in nature, and/or • carries a procedural risk, and/or • carries an anaesthetic risk, and/or • requires specialised training, and/or • requires special facilities or equipment only available in an acute care setting.

Data element concept attributes

Data element concept:	Episode of admitted patient care—procedure
Definition:	A **clinical intervention** that: • is surgical in nature, and/or • carries a procedural risk, and/or • carries an anaesthetic risk, and/or • requires specialised training, and/or • requires special facilities or equipment only available in an acute care setting.
Context:	This metadata item gives an indication of the extent to which specialised resources, for example, human resources, theatres and equipment, are used. It also provides an estimate of the numbers of surgical operations performed and the extent to which particular procedures are used to resolve medical problems. It is used for classification of episodes of acute care for admitted patients into Australian refined diagnosis related groups.
Object class:	Episode of admitted patient care
Property:	Procedure

Value domain attributes

Representational attributes

Classification scheme:	Australian Classification of Health Interventions (ACHI) 5th edition
Representation class:	Code
Data type:	Number
Format:	NNNNN-NN
Maximum character length:	7

Data element attributes

Collection and usage attributes

Collection methods: Record and code all procedures undertaken during the episode of care in accordance with the ACHI (5th edition). Procedures are derived from and must be substantiated by clinical documentation.

Comments: The National Centre for Classification in Health advises the National Health Data Committee of relevant changes to the ACHI.

Source and reference attributes

Origin: National Centre for Classification in Health
National Health Data Committee

Relational attributes

Related metadata references: Supersedes Episode of admitted patient care—procedure, code (ICD-10-AM 4th edn) NNNNN-NN NHIG, Superseded 07/12/2005

Implementation in Data Set Specifications: Admitted patient care NMDS 2006-2007 NHIG, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

Admitted patient care NMDS 2007-2008 NHIG, Standard 23/10/2006

Implementation start date: 01/07/2007

Information specific to this data set:
As a minimum requirement procedure codes must be valid codes from the Australian Classification of Health Interventions (ACHI) procedure codes and validated against the nationally agreed age and sex edits. More extensive edit checking of codes may be utilised within individual hospitals and state and territory information systems.

An unlimited number of diagnosis and procedure codes should be able to be collected in hospital morbidity systems. Where this is not possible, a minimum of 20 codes should be able to be collected.

Record all procedures undertaken during an episode of care in accordance with the ACHI (5th edition) Australian Coding Standards.

The order of codes should be determined using the following hierarchy:

- procedure performed for treatment of the principal diagnosis
- procedure performed for the treatment of an additional diagnosis
- diagnostic/exploratory procedure related to the principal diagnosis

- diagnostic / exploratory procedure related to an additional diagnosis for the episode of care.

Effective for collection from 01 / 07 / 2006

Profession labour force status of health professional

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Health professional—labour force status, code N{.N}
METeOR identifier:	270476
Registration status:	NHIG, Standard 01/03/2005
Definition:	Employment status of a health professional in a particular profession at the time of registration, as represented by a code.

Data element concept attributes

Data element concept:	Health professional—labour force status
Definition:	For the national health labour force collections, profession labour force status of a health professional in a particular profession is defined by employment status according to the classification/coding frame below at the time of renewal of registration.
Context:	Health labour force
Object class:	Health professional
Property:	Labour force status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N{.N}
Maximum character length:	2

Permissible values:

Value	Meaning
1	Employed in the profession: working in/practising the reference profession - in reference State
2	Employed in the profession: working in/practising the reference profession - mainly in other State(s) but also in reference State
3	Employed in the profession: working in/practising the reference profession - mainly in reference State but also in other State(s)
4	Employed in the profession: working in/practising the reference profession - only in State(s) other than reference State
5.1	Employed elsewhere, looking for work in the profession: in paid work not in the field of profession but looking for paid work/practice in the profession - seeking either full-time or part-time work
5.2	Employed elsewhere, looking for work in the profession: in paid work not in the field of profession but looking for paid work/practice

		in the profession - seeking full-time work
	5.3	Employed elsewhere, looking for work in the profession: in paid work not in the field of profession but looking for paid work / practice in the profession - seeking part-time work
	5.9	Employed elsewhere, looking for work in the profession: in paid work not in the field of profession but looking for paid work / practice in the profession - seeking work (not stated)
	6.1	Unemployed, looking for work in the profession: not in paid work but looking for work in the field of profession - seeking either full-time or part-time work
	6.2	Unemployed, looking for work in the profession: not in paid work but looking for work in the field of profession - seeking full-time work
	6.3	Unemployed, looking for work in the profession: not in paid work but looking for work in the field of profession - seeking part-time work
	6.9	Unemployed, looking for work in the profession: not in paid work but looking for work in the field of profession - seeking work (not stated)
	7	Not in the labour force for the profession: not in work / practice in the profession and not looking for work / practice in the profession
	8	Not in the labour force for the profession: working overseas
Supplementary values:	9	Unknown / not stated

Data element attributes

Collection and usage attributes

Guide for use:

Employment in a particular health profession is defined by practice of that profession or work that is principally concerned with the discipline of the profession (for example, research in the field of the profession, administration of the profession, teaching of the profession or health promotion through public dissemination of the professional knowledge of the profession).

The term 'employed in the profession' equates to persons who have a job in Australia in the field of the reference profession.

A person who is normally employed in the profession but is on leave at the time of the annual survey is defined as being employed.

A health professional who is not employed but is eligible to work in, and is seeking employment in the profession, is defined as unemployed in the profession.

A health professional looking for work in the profession, and not currently employed in the profession, may be either unemployed or employed in an occupation other than the profession.

A registered health professional who is not employed in the profession, nor is looking for work in the profession, is defined as not in the labour force for the profession.

Registered health professionals not in the labour force for the profession may be either not employed and not looking for work, or employed in another occupation and not looking for work in the profession.

Collection methods:

For the national health labour force collection survey questionnaire, this is the key filter question. It excludes from further survey questions at this point:

- persons working overseas although working / practising in the reference profession
- respondents working only in states other than the reference state
- respondents not working in the reference profession and not looking for work in the reference profession.

It also directs respondents working in the reference state and other states to respond to subsequent questions only in respect of work in the reference state. These distinctions are necessary in order to eliminate multiple counting for respondents renewing licenses to practise in more than one state.

Comments:

The definitions of employed and unemployed in this metadata item differ from Australian Bureau of Statistics (ABS) definitions for these categories defined in LFA2 'Employed persons', LFA8 'Labour force status', LFA9 'Looking for full-time work', LFA10 'Looking for part-time work', LFA12 'Not in the labour force', LFA13 'Status in employment', and LFA14 'Unemployed persons'.

The main differences are:

- The National Health Labour Force Collection includes persons other than clinicians working in the profession as persons employed in the profession. The ABS uses the Australian Standard Classification of Occupations where, in general, classes for health occupations do not cover non-clinicians. The main exception to this is nursing where, because of the size of the profession, there are classes for nursing administrators and educators.
- The labour force collection includes health professionals working in the Defence Forces; ABS does not, with the exception of the population census.
- ABS uses a tightly defined reference period for employment and unemployment; the labour force collection reference period is self-defined by the respondent as his / her usual status at the time of completion of the survey questionnaire.
- The labour force collection includes, among persons looking for work in the profession, those persons who are registered health professionals but employed in another occupation and looking for work in the profession; ABS does not.
- The labour force collection includes in the category not in the labour force health professionals registered in Australia but working overseas; such persons are excluded from the scope of ABS censuses and surveys.

Source and reference attributes

Submitting organisation: National Health Labour Force Data Working Group

Relational attributes

Related metadata references: Supersedes Profession labour force status of health professional, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Implementation in Data Set Specifications: Health labour force NMDS NHIG, Standard 01/03/2005

Implementation start date: 01/07/2005

Information specific to this data set:
This metadata item provides essential data for estimating the size and distribution of the health labour force, monitoring growth, forecasting future supply, and addressing work force planning issues. It was developed by the National Committee for Health and Vital Statistics during the 1980s and endorsed by the Australian Health Ministers Advisory Council in 1990 as a national minimum data set item for development of the national health labour force collections.

Proficiency in spoken English

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—proficiency in spoken English, code N
METeOR identifier:	270203
Registration status:	NHIG, Standard 01/03/2005 NCSIMG, Standard 01/03/2005 NHDAMG, Standard 10/02/2006
Definition:	A person's self-assessed level of ability to speak English, as represented by a code.

Data element concept attributes

Data element concept:	Person—proficiency in spoken English
Definition:	A person's self-assessed level of ability to speak English.
Object class:	Person
Property:	Proficiency in spoken English

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
0	Not applicable (persons under 5 years of age or who speak only English)
1	Very well
2	Well
3	Not well
4	Not at all

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 0 Not applicable (persons under 5 years of age or who speak only English)

Not applicable, is to be used for people under 5 year of age and people who speak only English.

CODE 9 Not stated/inadequately described

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.

Comments: The ABS advises that the most useful information provided by this metadata item is in the distinction between the two category groups of Very well/Well and Not well/Not at all.

Source and reference attributes

Reference documents: Standards for Statistics on Cultural and Language Diversity 1999. Cat. no. 1289.0. Canberra: ABS.

Data element attributes

Collection and usage attributes

Collection methods: This metadata item is only intended to be collected if a person has a main language other than English spoken at home; and / or first language spoken is not English.

Recommended question:

How well do you speak English? (tick one)

1. Very well
2. Well
3. Not well
4. Not at all

Generally this would be a self-reported question, but in some circumstances (particularly where a person does not speak English well) assistance will be required in answering this question. It is important that the person's self-assessed proficiency in spoken English be recorded wherever possible. This metadata item does not purport to be a technical assessment of proficiency but is a self-assessment in the four broad categories outlined above.

This metadata item is not relevant to and should not be collected for persons under the age of five years.

While agencies are encouraged to use the recommended question described above, it is acknowledged that this is not always possible in practice. For example, where the data collection is a by-product of the provision of a health or community service, the information may be ascertained using different means. However, this standard should be used wherever practically possible.

Comments: This metadata item identifies those people who may suffer disadvantage in terms of their ability to access services due to lack of ability in the spoken English language. This information can be used to target the provision of services to people whose lack of ability in spoken English is potentially a barrier to gaining access to government programs and services.

In conjunction with Indigenous status, the main language other than English spoken at home and the country of birth, this metadata item forms the minimum core set of cultural and language indicators recommended by the Australian Bureau of Statistics.

Source and reference attributes

Origin: National Health Data Committee

National Community Services Data Committee

Relational attributes

Related metadata references:

See also Person—main language other than English spoken at home, code (ASCL 2005) NN{NN} NHIG, Standard 08/02/2006, NCSIMG, Standard 29/04/2006, NHDAMG, Standard 10/02/2006

See also Person—country of birth, code (SACC 1998) NNNN NHIG, Standard 01/03/2005, NCSIMG, Standard 01/03/2005, NHDAMG, Standard 20/06/2005

Supersedes Proficiency in spoken English, version 2, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005

Progesterone receptor assay results

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person with cancer—progesterone receptor assay results, code N
METeOR identifier:	291341
Registration status:	NHIG, Standard 13/06/2004
Definition:	The results of progesterone receptor assay at the time or diagnosis of the primary breast tumour, as represented by a code.

Data element concept attributes

Data element concept:	Person with cancer—progesterone receptor assay results
Definition:	The results of progesterone receptor assay at the time of diagnosis of the primary breast tumour.
Object class:	Person with cancer
Property:	Progesterone receptor assay results

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values: / *Supplementary values:*

Value	Meaning
1	Test done, results positive (progesterone receptor positive)
2	Test done, results negative (Progesterone receptor negative)
0	Test not done (test not ordered or not performed)
8	Test done but results unknown
9	Unknown

Data element attributes

Collection and usage attributes

Collection methods:

The Australian Cancer Network Working Party established to develop guidelines for the pathology reporting of breast cancer recommends that hormone receptor assays be performed on all cases of invasive breast carcinoma. The report should include:

- the percentage of nuclei staining positive and the predominant staining intensity (low, medium, high), and
- a conclusion as to whether the assay is positive or negative.

Source and reference attributes

Origin:

Royal College of Pathologists of Australasia

Australian Cancer Network

Commission on Cancer American College of Surgeons

Reference documents:

Royal College of Pathologists of Australasia Manual of Use and Interpretation of Pathology Tests: Third Edition Sydney (2001)

Australian Cancer Network Working Party The pathology reporting of breast cancer. A guide for pathologists, surgeons and radiologists Second Edition Sydney (2001)

Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:

Supersedes Progesterone receptor assay status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Implementation in Data Set Specifications:

Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Cancer (clinical) DSS NHIG, Standard 07/12/2005

Information specific to this data set:
Hormone receptor status is an important prognostic indicator for breast cancer.

Proteinuria status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—proteinuria status, code N{.N}
METeOR identifier:	270346
Registration status:	NHIG, Standard 01/03/2005
Definition:	Whether there is a presence of excessive protein in the urine of the person, as represented by a code.

Data element concept attributes

Data element concept:	Person—proteinuria status
Definition:	The presence of excessive protein in the urine of the person.
Context:	Health care and clinical settings: Proteinuria is one of several indicators for renal disease or of conditions leading to renal disease. Renal disease when detected early is often responsive to intervention.
Object class:	Person
Property:	Proteinuria status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N{.N}
Maximum character length:	2

Permissible values:

Value	Meaning
1	Negative for protein
1.1	Microalbuminuria present
1.2	Microalbuminuria not present
1.3	Microalbuminuria not tested
2	Proteinuria
3	Not tested

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Negative for protein

Negative for proteinuria - less than 1 plus on dipstick-testing or excretion of 300 mg or less of protein from 24-hour urine collection.

CODE 1.1 Microalbuminuria present

Microalbuminuria present

CODE 1.2 Microalbuminuria not present

Microalbuminuria not present

CODE 1.3 Microalbuminuria not tested

Microalbuminuria not tested

CODE 2 Proteinuria

Proteinuria - one or more pluses of protein in dipstick urinalysis or for a 24-hour urine collection, where the patient excretes more than 300 mg / per day of protein.

CODE 3 Not tested

Not tested - no urinalysis for proteinuria was taken.

Collection methods: Where laboratory testing is used to determine Proteinuria status the categorisation must be substantiated by clinical documentation such as an official laboratory report.

Data element attributes

Collection and usage attributes

Collection methods: Dipstick testing can be used to test for protein in a urine specimen. Proteinuria (i.e. excessive protein in the urine) on dipstick urinalysis is described as one or more pluses of protein and for a 24-hour urine collection where the patient excretes more than 300 mg / day of protein.

Microalbuminuria can be determining using any one of the following tests: spot urine, timed urine (24-hour collection) or albumin / creatinine ratio. Although the presence of microalbuminuria does not warrant categorisation as proteinuria, it is clinically significant in the diagnosis and treatment of diabetes.

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 Patient—diagnosis date, DDMMYYYY should be recorded.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Relational attributes

Related metadata references: Supersedes Proteinuria - status, version 1, DE, NHDD, NHIMG, Superseded 01 / 03 / 2005

Implementation in Data Set Specifications: Cardiovascular disease (clinical) DSS NHIG, Superseded 15 / 02 / 2006

Cardiovascular disease (clinical) DSS NHIG, Superseded 04 / 07 / 2007

Cardiovascular disease (clinical) DSS NHIG, Standard 04 / 07 / 2007

Provider occupation category (self-identified)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Individual service provider—occupation (self-identified), code (ANZSCO 1st edition) N[NNN]{NN}
METeOR identifier:	350896
Registration status:	NHIG, Standard 04/07/2007 NCSIMG, Standard 27/03/2007
Definition:	A health care occupation that an individual provider identifies as being one in which they provide a significant amount of services, as represented by a code.

Data element concept attributes

Data element concept:	Individual service provider—occupation (self-identified)
Definition:	A health care occupation that an individual provider identifies as being one in which they provide a significant amount of services.
Object class:	Individual service provider
Property:	Occupation

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Value domain attributes

Representational attributes

Classification scheme:	Australian and New Zealand Standard Classification of Occupations, First edition, 2006
Representation class:	Code
Data type:	Number
Format:	N[NNN]{NN}
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:	The following is a list of the more common health care occupations, however, it is not intended to represent all the possible health care occupations: Aboriginal and Torres Strait Islander Health Worker (ANZSCO code 411511) Acupuncturist (ANZSCO code 252211) Aged or disabled carer (ANZSCO code 423111) Ambulance officer (ANZSCO code 411111) Anaesthetist (ANZSCO code 253211) Audiologist (ANZSCO code 252711) Chiropractor (ANZSCO code 252111)

Clinical psychologist (ANZSCO code 272311)
Complementary Health Therapists nec (ANZSCO code 252299)
Dental assistant (ANZSCO code 423211)
Dental hygienist (ANZSCO code 411211)
Dental specialist (ANZSCO code 252311)
Dental technician (ANZSCO code 411213)
Dental therapist (ANZSCO code 411214)
Dentist (ANZSCO code 252312)
Dermatologist(ANZSCO code 253911)
Dietitian (ANZSCO code 251111)
Drug and Alcohol Counsellor (ANZSCO code 272112)
Enrolled nurse (ANZSCO code 411411)
General medical practitioner (ANZSCO code 253111)
Health professionals (ANZSCO code 25)
Hospital pharmacist (ANZSCO code 251511)
Intensive care ambulance paramedic (Aus) / ambulance paramedic (NZ) (ANZSCO code 411112)
Massage therapist (ANZSCO code 411611)
Medical diagnostic radiographer (ANZSCO code 251211)
Medical practitioners nec (ANZSCO code 253999)
Medical radiation therapist (ANZSCO code 251212)
Midwife (ANZSCO code 254111)
Naturopath (ANZSCO code 252213)
Nuclear medicine technologist (ANZSCO code 251213)
Nurse educator (ANZSCO code 254211)
Nurse manager (ANZSCO code 254311)
Nurse practitioner (ANZSCO code 254411)
Nurse researcher (ANZSCO code 254212)
Nursing assistant support worker (ANZSCO code 423312)
Occupational therapist (ANZSCO code 252411)
Ophthalmologist (ANZSCO code 253914)
Optometrist (ANZSCO code 251411)
Orthoptist (ANZSCO code 251412)
Orthotist or Prosthetist (ANZSCO code 251912)
Osteopath (ANZSCO code 252112)
Paediatrician (ANZSCO code 253321)
Pathologist (ANZSCO code 253915)
Physiotherapist (ANZSCO code 252511)
Podiatrist (ANZSCO code 252611)
Psychiatrist (ANZSCO code 253411)
Psychologists nec (ANZSCO code 272399)
Radiologist (ANZSCO code 253916)
Registered nurse (developmental disability)(ANZSCO code 254416)
Registered nurse (mental health)(ANZSCO code 254422)
Registered Nurses nec (ANZSCO code 254499)
Rehabilitation counsellor (ANZSCO code 272114)
Retail pharmacist (ANZSCO code 251513)
Social worker (ANZSCO code 272511)
Sonographer (ANZSCO code 251214)

Specialist physician(general medicine) (ANZSCO code 253311)

Speech pathologist (aus) / speech language therapist (nz) (ANZSCO code 252712)

Surgeon (general) (ANZSCO code 253511)

Therapy aide (ANZSCO code 423314)

Collection methods:

Data is collected at the time a health care provider identification record is created.

Multiple instances of health care occupation may be collected where the individual provides a significant amount of services in more than one category. For example, a dentist who is also a medical practitioner may practice as both.

Record as many as apply.
Accurate data are best achieved using computer assisted coding. A computer assisted coding system is available from the ABS to assist in coding occupational data to ANZSCO codes.

Data coded at the 4-digit and 6-digit level will provide more detailed information than that collected at the higher levels and may be more useful. However, the level at which data are coded and reported will depend on the purpose of collecting this information.

Comments:

ANZSCO defines 'occupation' as 'a set of jobs with similar sets of tasks'. Operationally this is defined as 'a collection of jobs which are sufficiently similar in their main tasks to be grouped together for purposes of the classification'. Job is defined as 'a set of tasks designed to be performed by one individual for a wage or salary'.

Source and reference attributes

Reference documents:

In AS4846 this data element is referred to as 'Provider main field of practice'.

Relational attributes

Related metadata references:

Supersedes Individual service provider—occupation (self-identified), code (ASCO 2nd edn) N[NNN]{-NN} NHIG, Superseded 04/07/2007, NCSIMG, Superseded 27/03/2007

Implementation in Data Set Specifications:

Health care provider identification DSS NHIG, Standard 04/07/2007

Provider occupation end date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Individual service provider—occupation end date, DDMMYYYY
METeOR identifier:	289053
Registration status:	NHIG, Standard 04/05/2005 NCSIMG, Standard 30/09/2005
Definition:	The date on which an individual health care provider ceased practising in an identified occupation.

Data element concept attributes

Data element concept:	Individual service provider—occupation end date
Definition:	The date on which an individual health care provider ceased practising in an identified occupation.
Object class:	Individual service provider
Property:	Occupation end date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Implementation in Data Set Specifications:

Health care provider identification DSS NHIG, Superseded 04/07/2007

Health care provider identification DSS NHIG, Standard 04/07/2007

Information specific to this data set:
This date must:

- be greater than or equal to the provider occupation start date;
- be a valid date;
- be collected for each provider occupation recorded.

If the date is estimated in some way, it is recommended that the metadata item *Date accuracy indicator* also be recorded at the time of record creation to flag the accuracy

of the data.

For data integrity, data exchange, future data analysis and / or manipulation of data from diverse sources the *Date accuracy indicator* must be used in conjunction with the *provider occupation end date* in all instances to ensure accuracy.

Provider occupation start date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Individual service provider—occupation start date, DDMMYYYY
METeOR identifier:	289059
Registration status:	NHIG, Standard 04/05/2005 NCSIMG, Standard 30/09/2005
Definition:	The date on which an individual health care provider commenced practising in an identified occupation.

Data element concept attributes

Data element concept:	Individual service provider—occupation start date
Definition:	The date on which an individual health care provider commenced practising in an identified occupation.
Object class:	Individual service provider
Property:	Occupation start date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Implementation in Data Set Specifications:

Health care provider identification DSS NHIG, Superseded 04/07/2007

Health care provider identification DSS NHIG, Standard 04/07/2007

Information specific to this data set:
This date must:

- be greater than or equal to the provider occupation start date;
- be a valid date;
- be collected for each provider occupation recorded.

If the date is estimated in some way, it is recommended that the metadata item *Date accuracy indicator* also be

recorded at the time of record creation to flag the accuracy of the data.

For data integrity, data exchange, future data analysis and / or manipulation of data from diverse sources the *Date accuracy indicator* must be used in conjunction with the *provider occupation start date* in all instances to ensure accuracy.

Quality accreditation/certification standard—Australian Council on Healthcare Standards EQuIP

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—quality accreditation / certification standard indicator (Australian Council on Healthcare Standards EQuIP), code N
METeOR identifier:	302372
Registration status:	NHIG, Standard 14 / 09 / 2005
Definition:	Whether the Australian Council on Healthcare Standards EQuIP standard has been met by the hospital establishment as a whole, as represented by a code.

Data element concept attributes

Data element concept:	Establishment—quality accreditation / certification standard indicator
Definition:	The quality accreditation / certification standard met by the hospital establishment as a whole.
Context:	Hospitals: Required to identify the quality accreditation / certification standard met by the providers of services.
Object class:	Establishment
Property:	Quality accreditation / certification standard indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

Report the status code as at 30 June.

Code 1 Yes

Record if the hospital establishment is accredited or compliant with the standard.

Code 2 No

Record if the hospital establishment is not accredited or compliant with the standard.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Establishment—quality accreditation/certification standard status (Australian Council on Healthcare Standards EQuIP), code N NHIG, Superseded 14/09/2005

Quality accreditation/certification standard—Australian Quality Council

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—quality accreditation / certification standard indicator (Australian Quality Council), code N
METeOR identifier:	302374
Registration status:	NHIG, Standard 14 / 09 / 2005
Definition:	Whether the Australian Quality Council standard has been met by the hospital establishment as a whole, as represented by a code.

Data element concept attributes

Data element concept:	Establishment—quality accreditation / certification standard indicator
Definition:	The quality accreditation / certification standard met by the hospital establishment as a whole.
Context:	Hospitals: Required to identify the quality accreditation / certification standard met by the providers of services.
Object class:	Establishment
Property:	Quality accreditation / certification standard indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

Report the status code as at 30 June.

Code 1 Yes

Record if the hospital establishment is accredited or compliant with the standard.

Code 2 No

Record if the hospital establishment is not accredited or compliant with the standard.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Establishment—quality accreditation / certification standard status (Australian Quality Council), code N NHIG, Superseded 14 / 09 / 2005

Quality accreditation/certification standard—ISO 9000 quality family

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—quality accreditation / certification standard indicator (International Organisation for Standardisation 9000 quality family), code N
METeOR identifier:	302377
Registration status:	NHIG, Standard 14 / 09 / 2005
Definition:	Whether the International Organisation for Standardisation 9000 quality family standard has been met by the hospital establishment as a whole, as represented by a code.

Data element concept attributes

Data element concept:	Establishment—quality accreditation / certification standard indicator
Definition:	The quality accreditation / certification standard met by the hospital establishment as a whole.
Context:	Hospitals: Required to identify the quality accreditation / certification standard met by the providers of services.
Object class:	Establishment
Property:	Quality accreditation / certification standard indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

Report the status code as at 30 June.

Code 1 Yes

Record if the hospital establishment is accredited or compliant with the standard.

Code 2 No

Record if the hospital establishment is not accredited or compliant with the standard.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Establishment—quality accreditation/certification standard status (International Organisation for Standardisation 9000 quality family), code N NHIG, Superseded 14/09/2005

Quality accreditation/certification standard—Quality Improvement Council

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—quality accreditation / certification standard indicator (Quality Improvement Council), code N
METeOR identifier:	302379
Registration status:	NHIG, Standard 14 / 09 / 2005
Definition:	Whether the Quality Improvement Council standard has been met by the hospital establishment as a whole, as represented by a code.

Data element concept attributes

Data element concept:	Establishment—quality accreditation / certification standard indicator
Definition:	The quality accreditation / certification standard met by the hospital establishment as a whole.
Context:	Hospitals: Required to identify the quality accreditation / certification standard met by the providers of services.
Object class:	Establishment
Property:	Quality accreditation / certification standard indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

Report the status code as at 30 June.

Code 1 Yes

Record if the hospital establishment is accredited or compliant with the standard.

Code 2 No

Record if the hospital establishment is not accredited or compliant with the standard.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Establishment—quality accreditation / certification standard status (Quality Improvement Council), code N NHIG, Superseded 14 / 09 / 2005