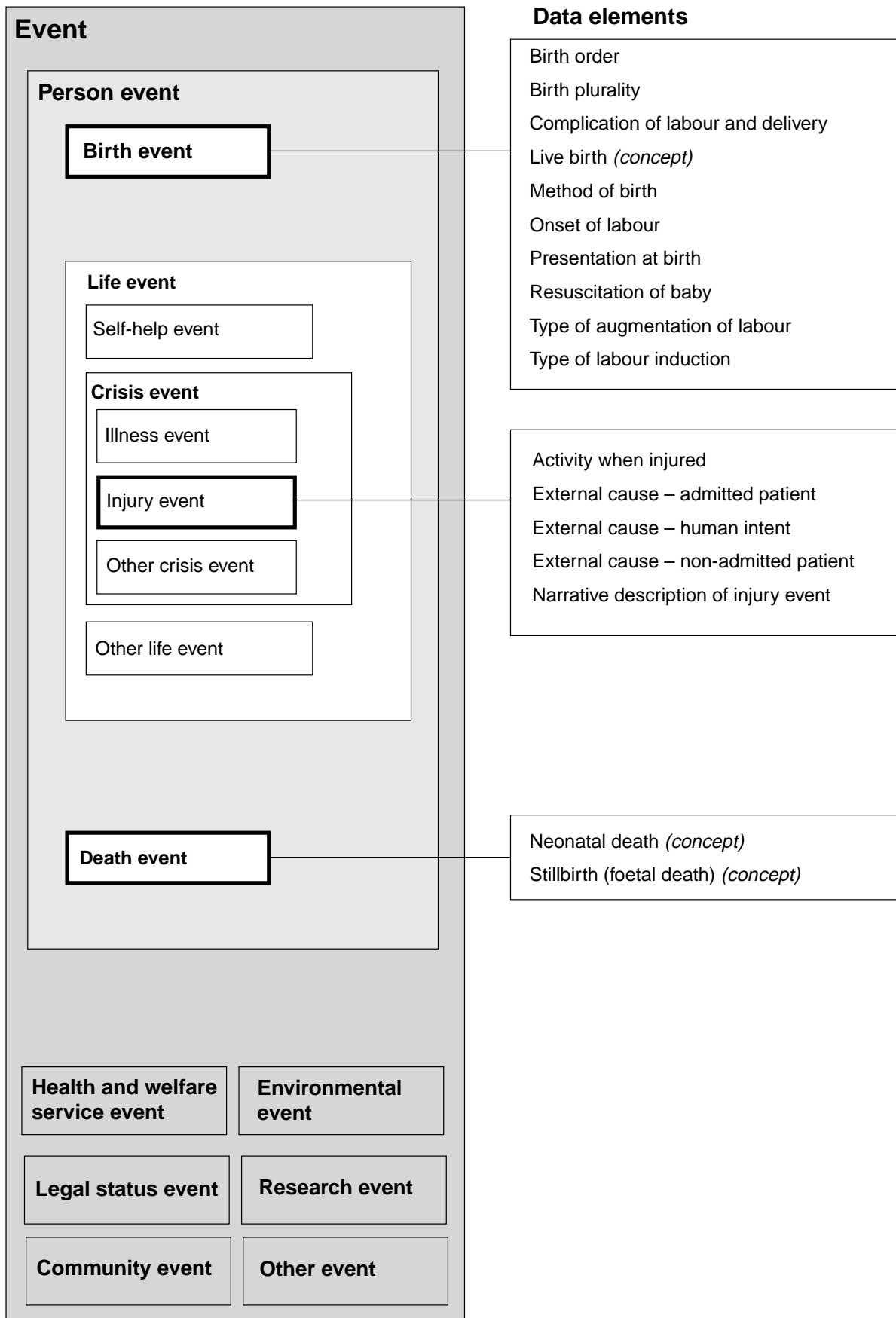


National Health Information Model entity



Birth order

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000019 Version number: 1

Data element type: DATA ELEMENT

Definition: The order of each baby of a multiple birth.

Context: Perinatal: required to analyse pregnancy outcome according to birth order and identify the individual baby resulting from a multiple birth pregnancy. Multiple births have higher risks of perinatal mortality and morbidity. Multiple birth pregnancies are often associated with obstetric complications, labour and delivery complications, higher rates of neonatal morbidity, low birthweight, and a higher perinatal death rate.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Singleton or first of a multiple birth
2	Second of a multiple birth
3	Third of a multiple birth
4	Fourth of a multiple birth
5	Fifth of a multiple birth
6	Sixth of a multiple birth
8	Other
9	Not stated

Related data: is a qualifier of Birth plurality, version 1

Administrative attributes

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Perinatal from 1/07/1997 to

Birth plurality

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000020 Version number: 1

Data element type: DATA ELEMENT

Definition: The total number of births resulting from this pregnancy.

Context: Perinatal: multiple pregnancy increases the risk of complications during pregnancy, labour and delivery and is associated with higher risk of perinatal morbidity and mortality.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Singleton
2	Twins
3	Triplets
4	Quadruplets
5	Quintuplets
6	Sextuplets
8	Other
9	Not stated

Guide for use: Plurality of a pregnancy is determined by the number of live births or by the number of foetuses that remain in utero at 20 weeks gestation and that are subsequently born separately. In multiple pregnancies, or if gestational age is unknown, only live births of any birthweight or gestational age, or foetuses weighing 400 g or more, are taken into account in determining plurality. Foetuses aborted before 20 completed weeks or foetuses compressed in the placenta at 20 or more weeks are excluded.

Related data: is qualified by Birth order, version 1

Administrative attributes

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Perinatal from 1/07/1997 to

Complication of labour and delivery

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000027 Version number: 2

Data element type: DATA ELEMENT

Definition: Medical and obstetric complications (necessitating intervention) arising after the onset of labour and before the completed delivery of the baby and placenta.

Context: Perinatal: complications of labour and delivery may cause maternal morbidity and may affect the health status of the baby at birth.

Relational and representational attributes

Datatype: Alphanumeric Field size: Min. 3 Max. 6 Layout: ANN.NN

Data domain: ICD-10-AM (2nd edition)

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

Verification rules: Complications should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM (2nd edition)

Related data: used in conjunction with Presentation at birth, version 1
used in conjunction with Method of birth, version 1
used in conjunction with Perineal status, version 1
supersedes previous data element Complication of labour and delivery – ICD-9-CM code, version 1
used in conjunction with Postpartum complication, version 2

Administrative attributes

Source document: International Statistical Classification of Diseases and Related health Problems – 10th Revision, Australian Modification 2nd Edition (July 2000) National Centre for Classification in Health, Sydney.

Source organisation: National Perinatal Data Development Committee

Live birth

Admin. status: CURRENT 1/07/1994

Identifying and definitional attributes

Knowledgebase ID: 000083 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: A live birth is defined by the World Health Organization to be the complete expulsion or extraction from the mother of a baby, irrespective of the duration of the pregnancy which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of the voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born.

Context: Perinatal:

Relational and representational attributes

Related data: relates to Status of the baby, version 1

Administrative attributes

Source document: International Classification of Diseases and Related Health Problems, 10th Revision, Vol. 1, WHO 1992

Source organisation: National Health Data Committee, National Perinatal Data Development Committee

Method of birth

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000093 Version number: 1

Data element type: DATA ELEMENT

Definition: The method of complete expulsion or extraction from its mother of a product of conception.

Context: Perinatal: the method of delivery may affect the health status of the mother and the baby at birth and during the postpartum period.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Spontaneous vaginal
2	Forceps (assisted vaginal birth)
3	Vaginal breech
4	Caesarean section
5	Vacuum extraction
8	Other
9	Not stated

Guide for use: In a vaginal breech with forceps to the aftercoming head, code as vaginal breech.

Related data: used in conjunction with Presentation at birth, version 1

Administrative attributes

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Perinatal from 1/07/1997 to

Onset of labour

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000113 Version number: 2

Data element type: DATA ELEMENT

Definition: Manner in which labour started.

Context: Perinatal: 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.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Spontaneous
2	Induced
3	No labour
9	Not stated

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.

Verification rules: 'No labour' can only be associated with caesarean section.

Collection methods: 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.

Related data: supersedes previous data element Onset of labour, version 1
used in conjunction with Type of labour induction, version 1
used in conjunction with Method of birth, version 1

Administrative attributes

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Perinatal from 1/07/2000 to

Presentation at birth

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000133 Version number: 1

Data element type: DATA ELEMENT

Definition: Presenting part of the foetus (at lower segment of uterus) at birth.

Context: Perinatal: presentation types other than vertex are associated with higher rates of caesarean section, instrumental delivery, perinatal mortality and neonatal morbidity.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	Vertex
2	Breech
3	Face
4	Brow
8	Other
9	Not stated

Related data: used in conjunction with Method of birth, version 1

Administrative attributes

Source organisation: National Perinatal Data Development Committee

Resuscitation of baby

Admin. status: CURRENT 1/07/2001

Identifying and definitional attributes

Knowledgebase ID: 000145 Version number: 2

Data element type: DATA ELEMENT

Definition: Active measures taken immediately after birth to establish independent respiration and heart beat, or to treat depressed respiratory effort and to correct metabolic disturbances.

Context: Perinatal: required to analyse need for resuscitation after complications of labour and delivery and to evaluate level of services needed for different birth settings.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

1	None
2	Suction only
3	Oxygen therapy only
4	Intermittent positive pressure respiration (IPPR) through bag and mask
5	Endotracheal intubation and IPPR
6	External cardiac massage and ventilation
9	Not stated

Guide for use: This item does not include drug therapy. Code the most severe measure used. If oxygen is given by bag and mask without IPPR, code as 'oxygen therapy'.

Related data:

- supersedes previous Resuscitation of baby, version 1
- used in conjunction with Status of the baby, version 1
- used in conjunction with Apgar score at 1 minute, version 1
- used in conjunction with Apgar score at 5 minutes, version 1

Administrative attributes

Source organisation: National Perinatal Data Development Committee

Type of augmentation of labour

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000167 Version number: 2

Data element type: DATA ELEMENT

Definition: Methods used to assist progress of labour.

Context: Perinatal: type of augmentation determines the progress and duration of labour and may influence the method of delivery and the health status of the baby at birth.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

0	None
1	Oxytocin
2	Prostaglandins
3	Artificial rupture of membranes (ARM)
4	Other
5	Not stated

Guide for use: More than one method of augmentation can be recorded, except where 0=none applies.

Verification rules: Collection units need to edit carefully the use of prostaglandins as an augmentation method. Results from checking records have shown that either the onset of labour was incorrect or that the augmentation method was incorrectly selected.

Related data: supersedes previous Type of augmentation of labour, version 1
used in conjunction with Onset of labour, version 2
used in conjunction with Type of labour induction, version 1
used in conjunction with Method of birth, version 1

Administrative attributes

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Perinatal from 1/07/2000 to

Comments: Prostaglandin is listed as a method of augmentation in the data domain. Advice from RANZCOG and the manufacturer indicates that vaginal prostaglandin use is not recommended or supported as a method of augmentation of labour as it may significantly increase the risk of uterine hyperstimulation. In spite of this, the method is being used and it is considered important to monitor its use for augmentation.

Type of labour induction

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000171 Version number: 1

Data element type: DATA ELEMENT

Definition: Methods used to induce labour.

Context: Perinatal: type of induction determines the progress and duration of labour and may influence the method of delivery and the health status of the baby at birth.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 1 Layout: N

Data domain:

0	None
1	Oxytocin
2	Prostaglandins
3	Artificial rupture of membranes (ARM)
4	Other

Guide for use: More than one method of induction can be recorded, except where 0=none applies.

Related data: used in conjunction with Onset of labour, version 2
used in conjunction with Type of augmentation of labour, version 2

Administrative attributes

Source organisation: National Perinatal Data Development Committee

Activity when injured

Admin. status: CURRENT 1/07/2000

Identifying and definitional attributes

Knowledgebase ID: 000002 Version number: 2

Data element type: DATA ELEMENT

Definition: The type of activity being undertaken by the person when injured.

Context: Injury surveillance: enables categorisation of injury and poisoning according to factors important for injury control. Necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research. This item is the basis for identifying work-related and sport-related injuries.

Relational and representational attributes

Datatype: Numeric Field size: Min. 1 Max. 2 Layout: NN

Data domain:

0	Sports activity
00	Football, rugby
01	Football, Australian
02	Football, soccer
03	Hockey
04	Squash
05	Basketball
06	Netball
07	Cricket
08	Roller blading
09	Other and unspecified sporting activity
1	Leisure activity (excluding sporting activity)
2	Working for income
3	Other types of work
4	Resting, sleeping, eating or engaging in other vital activities
5	Other specified activities
9	Unspecified activities

Guide for use: Admitted patients: Use the appropriate codes as fourth and fifth characters to Y93 when using the ICD-10-AM (2nd edition). Used with ICD-10-AM external cause codes V01–Y34 and assigned according to the Australian Coding Standards.

Non-admitted patients: 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 activity being

undertaken by the person when injured, 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

Verification rules: Admitted patients: to be used with ICD-10-AM (2nd edition) external cause codes V01 –Y34 only.

Related data: supersedes previous data element Activity when injured – version 1
used in conjunction with External Cause – major external cause, version 3
used in conjunction with External cause – human intent, version 4
is a qualifier of Narrative description of injury event, version 1
used in conjunction with Nature of main injury – non-admitted patient, version 1
used in conjunction with Bodily location of main injury, version 1

Administrative attributes

Source document: ICD-10-AM (2nd edition)

Source organisation: National Centre for Classification in Health, National Injury Surveillance Unit

National minimum data sets:

Admitted patient care from 1/07/2000 to

Injury surveillance from 1/07/2000 to

External cause—admitted patient

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000053 Version number: 4

Data element type: DATA ELEMENT

Definition: Environmental event, circumstance or condition as the cause of injury, poisoning and other adverse effect.

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

Relational and representational attributes

Datatype: Alphanumeric Field size: Min. 3 Max. 6 Layout: ANN.NN

Data domain: ICD-10-AM (2nd edition)

Guide for use: This code must be used in conjunction with an injury or poisoning codes and can be used with other disease codes. Admitted patients should be coded to the complete ICD-10-AM (2nd edition) classification.

An external cause code should be sequenced following the related injury or poisoning code, or following the group of codes, if more than one injury or condition has resulted from this external cause. Provision should be made to record more than one external cause if appropriate.

External cause codes in the range W00 to Y34, except Y06 and Y07 must be accompanied by a place of occurrence code (data element Place of occurrence of external cause).

External cause codes V01 to Y34 must be accompanied by an activity code (data element Activity when injured).

Verification rules: As a minimum requirement, the external cause codes must be listed in the ICD-10-AM (2nd edition) classification.

Related data: used in conjunction with Activity when injured, version 2
used in conjunction with Place of occurrence of external cause, version 2
supersedes previous data element External cause—admitted patient—ICD-9-CM code, version 3
used in conjunction with Principal diagnosis, version 3
used in conjunction with Additional diagnosis, version 4

Administrative attributes

Source document: International Statistical Classification of Diseases and Related Health Problems—Tenth Revision—Australian Modification 2nd Edition (July 2000) National Centre for Classification in Health, Sydney.

Source organisation: National Health Data Committee, National Centre for Classification in Health and National Data Standards for Injury Surveillance Advisory Group

National minimum data sets:

Admitted patient care from 1/07/2000 to

Injury surveillance from 1/07/1989 to

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

External cause—human intent

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000382 Version number: 4

Data element type: DATA ELEMENT

Definition: The most likely role of human intent in the occurrence of the injury or poisoning as assessed by clinician.

Context: Injury surveillance: enables categorisation of injury and poisoning according to factors important for injury control. This information is necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research.

Relational and representational attributes

Datatype: Numeric Field size: Min. 2 Max. 2 Layout: NN

Data domain:

- 01 Accident—injury not intended
- 02 Intentional self harm
- 03 Sexual assault
- 04 Maltreatment by parent
- 05 Maltreatment by spouse or partner
- 06 Other and unspecified assault
- 07 Event of undetermined intent
- 08 Legal intervention (including police) or operations of war
- 09 Adverse effect or complications of medical and surgical care
- 10 Other specified intent
- 11 Intent not specified

Guide for use: Select the item which best characterises the role of intent in the occurrence of the injury, on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one that comes first in the code list.

This item must always be accompanied by an External cause—non-admitted patient code.

This data domain is for use in injury surveillance purposes only, when it is not possible to use a complete ICD-10-AM code (e.g. non-admitted patients in Emergency Departments).

Related data:

- supersedes previous External cause—human intent, version 3
- used in conjunction with Place of occurrence of external cause of injury, version 5
- used in conjunction with Narrative description of injury event, version 1
- used in conjunction with Nature of main injury—non-admitted patient, version 1
- used in conjunction with Bodily location of main injury, version 1
- used in conjunction with Activity when injured, version 2

Administrative attributes

Source organisation: National Health Data Committee; National Data Standards for Injury Surveillance Advisory Group

National minimum data sets:

Injury surveillance

from 1/07/1989 to

External cause—non-admitted patient

Admin. status: CURRENT 1/07/1998

Identifying and definitional attributes

Knowledgebase ID: 000381 Version number: 4

Data element type: DATA ELEMENT

Definition: Event, circumstance or condition associated with the occurrence of injury, poisoning or adverse effect.

Context: Injury surveillance: enables categorisation of injury and poisoning according to factors important for injury control. This information is necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research.

Relational and representational attributes

Datatype: Numeric Field size: Min. 2 Max. 2 Layout: NN

Data domain:

- 01 Motor vehicle—driver
- 02 Motor vehicle—passenger or unspecified occupant
- 03 Motorcycle—driver
- 04 Motorcycle—passenger or unspecified
- 05 Pedal cyclist or pedal cycle passenger
- 06 Pedestrian
- 07 Other or unspecified transport-related circumstance
- 08 Horse-related (includes fall from, struck or bitten by)
- 09 Fall—low (on same level or < 1 metre or no information on height)
- 10 Fall—high (drop of 1 metre or more)
- 11 Drowning, submersion—swimming pool
- 12 Drowning, submersion—other than swimming pool (excludes drowning associated with water craft [07])
- 13 Other threat to breathing (including strangling and asphyxiation)
- 14 Fire, flames, smoke
- 15 Hot drink, food, water, other fluid, steam, gas or vapour
- 16 Hot object or substance, not otherwise specified
- 17 Poisoning—drugs or medicinal substance
- 18 Poisoning—other substance
- 19 Firearm
- 20 Cutting, piercing object
- 21 Dog-related
- 22 Animal-related (excluding Horse [08] and Dog [21])
- 23 (deleted)
- 24 Machinery in operation
- 25 Electricity
- 26 Hot conditions (natural origin) sunlight

Data domain (continued):	27	Cold conditions (natural origins)
	28	Other specified external cause
	29	Unspecified external cause
	30	Struck by or collision with person
	31	Struck by or collision with object

Guide for use: This data domain is for use in injury surveillance purposes only, when it is not possible to use a complete ICD-10-AM (2nd edition) code (e.g. Non-admitted patients in Emergency Departments).

Select the item which best characterises the circumstances of the injury, on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate select the one that comes first in the code list.

The External cause – non-admitted patient group must always be accompanied by an External cause – human intent code (see data element External cause – human intent – injury surveillance).

Related data: supersedes previous External cause – major external cause, version 3
used in conjunction with Place of occurrence of external cause of injury, version 5
used in conjunction with Narrative description of injury event, version 1
used in conjunction with Nature of main injury – non-admitted patient, version 1
used in conjunction with Bodily location of main injury, version 1
used in conjunction with Activity when injured, version 2
used in conjunction with External cause – human intent, version 4

Administrative attributes

Source organisation: National Health Data Committee; National Centre for Classification in Health; and National Data Standards for Injury Surveillance Advisory Group

Comments: This item has been developed to cater for the information requirements of the wide range of settings undertaking injury surveillance who do not have the capability of recording the complete ICD-10-AM external cause codes. This code list has been derived from the ICD-10-AM external cause classification. Further information on the national injury surveillance program can be obtained from the National Injury Surveillance Unit, Flinders University, Adelaide.

Narrative description of injury event

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000099 Version number: 1

Data element type: DATA ELEMENT

Definition: A text description of the injury event.

Context: Injury surveillance: 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.

Relational and representational attributes

Datatype: Alphanumeric Field size: Min. 0 Max. 100 Layout: free text

Data domain: Text up to 100 characters in length

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 also be indicated.

Related data: is qualified by External cause—human intent, version 3
is qualified by Activity when injured, version 2

Administrative attributes

Source organisation: National Injury Surveillance Unit

National minimum data sets:

Injury surveillance from 1/07/1989 to

Comments: 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.

Neonatal death

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000101 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: The death of a live birth which occurs during the first 28 days of life. This may be subdivided into early neonatal deaths, occurring during the first seven days of life, and late neonatal deaths, occurring after the seventh day but before 28 completed days of life.

Context: Perinatal:

Relational and representational attributes

Related data: relates to Status of the baby, version 1

Administrative attributes

Source document: International Classification of Diseases, 10th Revision, WHO, 1992

Source organisation: National Perinatal Data Development Committee

Comments: Age at death during the first day of life (day zero) should be recorded in units of completed minutes or hours of life. For the second (day one), third (day two) and through 27 completed days of life, age at death should be recorded in days (WHO 1992).

Stillbirth (foetal death)

Admin. status: CURRENT 1/07/1996

Identifying and definitional attributes

Knowledgebase ID: 000160 Version number: 1

Data element type: DATA ELEMENT CONCEPT

Definition: A foetal death prior to the complete expulsion or extraction from its mother of a product of conception of 20 or more completed weeks of gestation or of 400 g or more birthweight; the death is indicated by the fact that after such separation the foetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

Context: Perinatal:

Administrative attributes

Source organisation: National Perinatal Data Development Committee

Comments: The WHO definition of live birth, and the legal definition used in Australian States and Territories, do not specify any lower limit for gestational age or birthweight. In practice, liveborn foetuses of less than 20 weeks' gestation are infrequently registered as live births. In analysing data from the perinatal collections, it is recommended that the same criteria of gestational age and birthweight should be used for live births and stillbirths. Births for which gestational age and birthweight have not been recorded (usually occurring outside hospitals) should be included in the perinatal collections if it seems likely that the criteria have been met.

Terminations of pregnancy performed at gestational ages of 20 or more weeks should be included in perinatal collections and should be recorded either as stillbirths or, in the unlikely event of showing evidence of life, as live births.