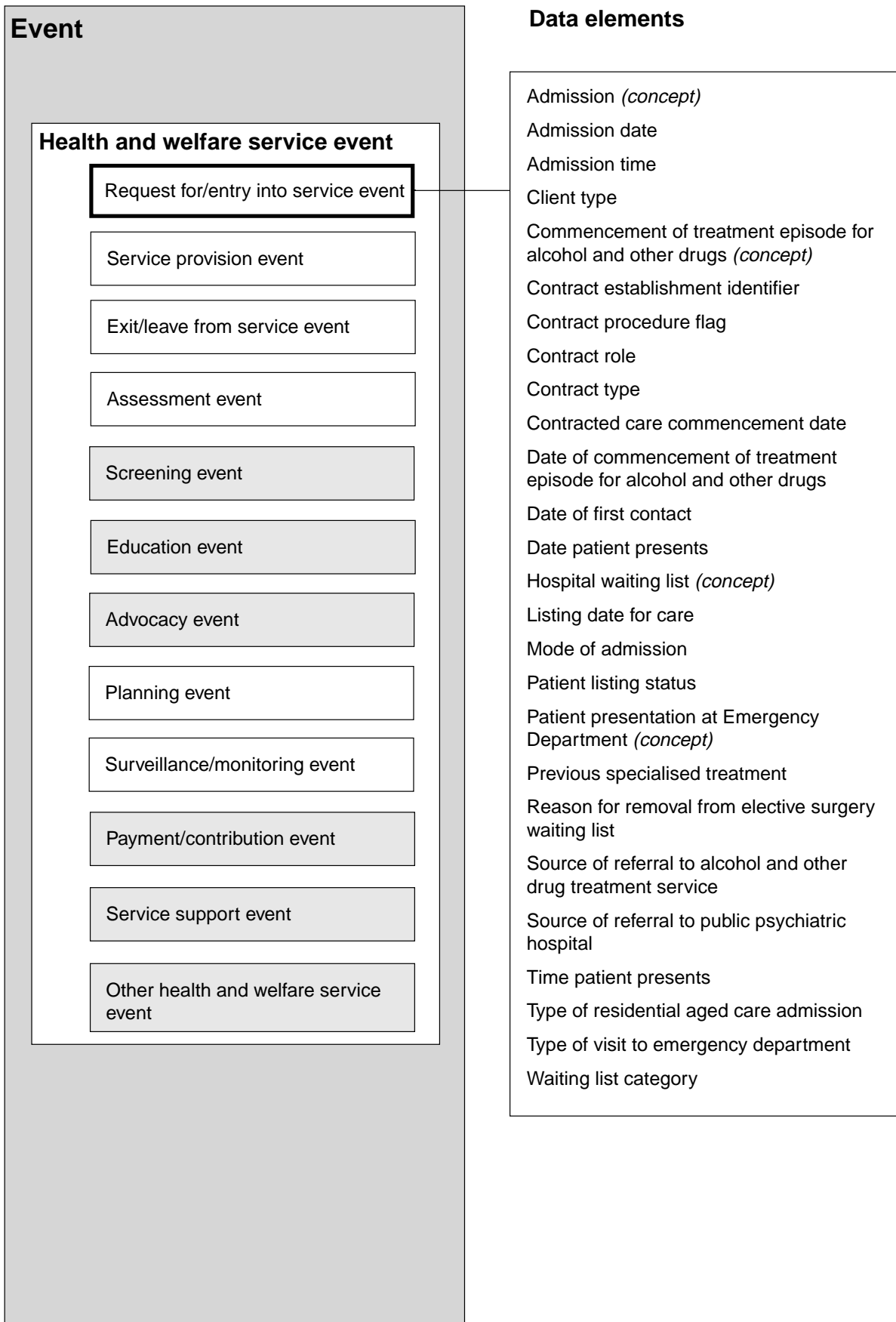


# National Health Information Model entity



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## Admission

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*Admin. status:* CURRENT 1/07/2000

### Identifying and definitional attributes

*Knowledgebase ID:* 000007 Version number: 3

*Data element type:* DATA ELEMENT CONCEPT

*Definition:* Admission is the process whereby the hospital accepts responsibility for the patient's care and/or treatment. Admission follows a clinical decision based upon specified criteria that a patient requires same-day or overnight care or treatment. An admission may be formal or statistical.

Formal admission: The administrative process by which a hospital records the commencement of treatment and/or care and/or accommodation of a patient.

Statistical admission is the administrative process by which a hospital records the commencement of a new episode of care, with a new care type, for a patient within one hospital stay.

*Context:* Admitted patient care:

### Relational and representational attributes

*Guide for use:* This treatment and/or care provided to a patient following admission occurs over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients).

*Related data:* supersedes previous data element concept Admission, version 2  
relates to concept Episode of care, version 1  
relates to concept Admitted patient, version 3  
relates to Admission date, version 4  
relates to Admission time, version 2  
relates to concept Separation, version 3

### Administrative attributes

*Source organisation:* National Health Data Committee

*Comments:* See the data element concept Admitted patient for the minimum criteria which must be met before a patient can be admitted to hospital.

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## Admission date

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*Admin. status:* CURRENT 1/07/1999

### Identifying and definitional attributes

*Knowledgebase ID:* 000008 Version number: 4

*Data element type:* DATA ELEMENT

*Definition:* Date on which an admitted patient commences an episode of care.

*Context:* Required to identify the period in which the admitted patient episode and hospital stay occurred and for derivation of length of stay.

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

*Data domain:* Valid date

*Verification rules:* Right justified and zero filled.  
Admission date ≤ separation date.  
Admission date ≥ date of birth

*Related data:* is used in the calculation of Length of stay, version 3  
supersedes previous data element Admission date, version 3  
is used in the derivation of Diagnosis related group, version 1  
is used in the calculation of Emergency Department waiting time to admission, version 1  
relates to Type of visit to Emergency Department, version 2  
relates to Departure status, version 1  
used in conjunction with Care type, version 4  
relates to concept Admitted patient, version 3  
is used in the calculation of Waiting time at admission, version 1  
relates to concept Admission, version 3  
relates to Admission time, version 2

### Administrative attributes

*Source organisation:* National Health Data Committee

#### *National minimum data sets:*

Admitted patient care from 1/07/2000 to

Admitted patient mental health care from 1/07/2000 to

Admitted patient palliative care from 1/07/2000 to

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## Admission time

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*Admin. status:* CURRENT 1/07/1999

### Identifying and definitional attributes

*Knowledgebase ID:* 000358 Version number: 2

*Data element type:* DATA ELEMENT

*Definition:* Time at which an admitted patient commences an episode of care.

*Context:* Admitted patient care: Required to identify the time of commencement of the episode or hospital stay, for calculation of waiting times and length of stay.

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 4 Max. 4 Layout: HHMM

*Data domain:* Expressed as hours and minutes using 24-hour clock

*Related data:* relates to Type of visit to Emergency Department, version 2  
supersedes previous data element Admission time, version 1  
relates to Departure status, version 1  
relates to concept Admitted patient, version 3  
relates to concept Admission, version 3  
used in conjunction with Admission date, version 4

### Administrative attributes

*Source organisation:* National Health Data Committee

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## Client type

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*Admin. status:* CURRENT 1/07/2000

### Identifying and definitional attributes

*Knowledgebase ID:* 000426 Version number: 1

*Data element type:* DATA ELEMENT

*Definition:* The status of a person in terms of whether contact with the service concerns their own alcohol and/or other drug use or that of another person.

*Context:* Alcohol and other drug treatment services: Required to differentiate between clients to provide a basis for description of the people accessing alcohol and other drug treatment services.

### Relational and representational attributes

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

*Data domain:*

- 1 Own drug use
- 2 Other's drug use
- 3 Both own and other's drug use
- 9 Not stated/inadequately described

*Guide for use:*

- Code 1 A client who contacts a service to receive treatment or assistance concerning their own alcohol and/or other drug use. These clients are sometimes referred to as primary clients..
- Code 2 A client who contacts a service to receive support and/or assistance in relation to the alcohol and/or other drug use of another person. These clients are sometimes referred to as secondary clients.
- Code 3 A client who contacts a service to receive treatment or assistance concerning both their own alcohol and/or other drug use and the alcohol and/or other drug use of another person.

*Collection methods:* To be collected on commencement of treatment with a service.

### Administrative attributes

*Source organisation:* Intergovernmental Committee on Drugs NMDS-WG

*National minimum data sets:*

Alcohol and other drug treatment services from 1/07/2000 to

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## Commencement of treatment episode for alcohol and other drugs

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*Admin. status:* CURRENT 01/07/2001

### Identifying and definitional attributes

*Knowledgebase ID:* 000427 Version number: 2

*Data element type:* DATA ELEMENT CONCEPT

*Definition:* Commencement of a treatment episode for alcohol and other drugs is the first service contact when assessment and/or treatment occurs with the treatment provider.

*Context:* Alcohol and other drug treatment services:

### Relational and representational attributes

*Guide for use:* A client is identified as commencing a treatment episode if one or more of the following apply:

- they are a new client;
- they are a client recommencing treatment after they have had no contact with the treatment provider for a period of three months or had any plan in place for further contact;
- their 'principal drug of concern for alcohol and other drugs' has changed;
- their 'main treatment type for alcohol and other drugs' has changed; or
- their 'treatment delivery setting for alcohol and other drugs' has changed.

*Related data:* supersedes previous concept Commencement of treatment, version 1  
relates to the data element Date of commencement of treatment episode for alcohol and other drugs, version 2

### Administrative attributes

*Source organisation:* Intergovernmental Committee on Drugs NMDS-WG

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## Contract establishment identifier

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*Admin. status:* CURRENT 1/07/2000

### Identifying and definitional attributes

*Knowledgebase ID:* 000416 Version number: 1

*Data element type:* DATA ELEMENT

*Definition:* The establishment identifier of the other hospital involved in the contracted care.

*Context:* Admitted patient care: and public hospital establishments.

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 6 Max. 6 Layout: NNANNN

*Data domain:* Valid identification number

*Guide for use:* The contracted hospital will record the establishment identifier of the contracting hospital.

The contracting hospital will record the establishment identifier of the contracted hospital.

*Related data:* relates to Establishment identifier, version 3

relates to concept Contracted hospital care, version 1

relates to Contract type, version 1

relates to Contract role, version 1

relates to Contracted care commencement date, version 1

relates to Contracted care completion date, version 1

relates to Total contract patient days, version 1

relates to Contract procedure flag, version 1

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## Contract procedure flag

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*Admin. status:* CURRENT 1/07/2000

### Identifying and definitional attributes

*Knowledgebase ID:* 000417 Version number: 1

*Data element type:* DATA ELEMENT

*Definition:* Designation that a procedure was not performed in this hospital but was performed by another hospital as a contracted service.

*Context:* Admitted patient care:

### Relational and representational attributes

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

*Data domain:*

- 1 Contracted admitted procedure
- 2 Contracted non-admitted procedure

Otherwise blank

*Guide for use:* Procedures performed at another hospital under contract (Hospital B) are recorded by both hospitals, but flagged by the contracting hospital only (Hospital A). This flag is to be used by the contracting hospital to indicate a procedure performed by a contracted hospital. It also indicates whether the procedure was performed as an admitted or non-admitted service.

Allocation of procedure codes should not be affected by the contract status of an episode: the Australian Coding Standards should be applied when coding all episodes. In particular, procedures which would not otherwise be coded should not be coded solely because they were performed at another hospital under contract.

Procedures performed by a health care service (i.e. not a recognised hospital) should be coded if appropriate. Some jurisdictions may require these to be separately identified and they could be distinguished from contracted hospital procedures through the use of an additional code in the contract procedure flag data item.

*Related data:*

- relates to concept Contracted hospital care, version 1
- relates to Contract type, version 1
- relates to Contract role, version 1
- relates to Contract establishment identifier, version 3
- relates to Contracted care commencement date, version 1
- relates to Contracted care completion date, version 1
- relates to Total contract patient days, version 1

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## Contract role

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*Admin. status:* CURRENT 1/07/2000

### Identifying and definitional attributes

*Knowledgebase ID:* 000418 Version number: 1

*Data element type:* DATA ELEMENT

*Definition:* Identifies whether the hospital is the purchaser of hospital care (contracting hospital) or the provider of an admitted or non-admitted service (contracted hospital).

*Context:* Admitted patient care: and public hospital establishments.

### Relational and representational attributes

*Datatype:* Alphabetic Field size: Min. 1 Max. 1 Layout: A

*Data domain:* A Hospital A  
B Hospital B

*Guide for use:* Hospital A is the contracting hospital (purchaser).  
Hospital B is the contracted hospital (provider).

*Related data:* relates to concept Contracted hospital care, version 1  
relates to Contract type, version 1  
relates to Contract establishment identifier, version 3  
relates to Contracted care commencement date, version 1  
relates to Contracted care completion date, version 1  
relates to Total contract patient days, version 1  
relates to Contract procedure flag, version 1

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## Contract type

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*Admin. status:* CURRENT 1/07/2000

### Identifying and definitional attributes

*Knowledgebase ID:* 000419 Version number: 1

*Data element type:* DATA ELEMENT

*Definition:* Contract Type describes the contract arrangement between the contractor and the contracted hospital. Contract types are distinguished by the physical movement of the patient between the contracting (where applicable) and contracted hospitals.

*Context:* Admitted patient care: and public hospital establishments.

### Relational and representational attributes

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

*Data domain:*

1	Contract type B
2	Contract type ABA
3	Contract type AB
4	Contract type (A)B
5	Contract type BA

*Guide for use:* The contracting hospital (purchaser) is termed Hospital A.  
The contracted hospital (provider) is termed Hospital B.

1 Contract Type B  
A health authority/other external purchaser contracts hospital B for admitted service which is funded outside the standard funding arrangements.

2 Contract Type ABA

- Patient admitted by Hospital A.
- Hospital A contracts Hospital B for admitted or non-admitted patient service.
- Patient returns to Hospital A on completion of service by Hospital B.

*Example:* a patient has a hip replacement at Hospital A, then receives aftercare at Hospital B, under contract to Hospital A. Complications arise and the patient returns to Hospital A for the remainder of care.

3 Contract Type AB

- Patient admitted by Hospital A.
- Hospital A contracts Hospital B for admitted or non-admitted patient service.
- Patient does not return to Hospital A on completion of service by Hospital B.

*Example:* a patient has a hip replacement at Hospital A and then receives aftercare at Hospital B, under contract to Hospital A. Patient is separated from Hospital B.

**Guide for use  
(continued):**

- 4 Contract Type (A)B  
This contract type occurs where a Hospital A contracts Hospital B for the whole episode of care. The patient does not attend Hospital A.  
*Example:* a patient is admitted for endoscopy at Hospital B under contract to Hospital A.
- 5 Contract Type BA  
Hospital A contracts Hospital B for an admitted patient service following which the patient moves to Hospital A for remainder of care.  
*Example:* a patient is admitted to Hospital B for a gastric resection procedure under contract to Hospital A and Hospital A provides after care.

**Related data:**

- relates to concept Contracted hospital care, version 1  
relates to Contract role, version 1  
relates to Contract establishment identifier, version 3  
relates to Contracted care commencement date, version 1  
relates to Contracted care completion date, version 1  
relates to Total contract patient days, version 1  
relates to Contract procedure flag, version 1

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## Contracted care commencement date

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*Admin. status:* CURRENT 1/07/2000

### Identifying and definitional attributes

*Knowledgebase ID:* 000420 Version number: 1

*Data element type:* DATA ELEMENT

*Definition:* The date the period of contracted care commenced.

*Context:* Admitted patient care:

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

*Data domain:* Valid dates

*Guide for use:* This item is to be used by the contracting hospital to record the commencement date of the contracted hospital care and will be the admission date for the contracted hospital.

*Related data:*

- relates to concept Contracted hospital care, version 1
- relates to Contract type, version 1
- relates to Contract role, version 1
- relates to Contract establishment identifier, version 3
- relates to Contracted care completion date, version 1
- relates to Total contract patient days, version 1
- relates to Contract procedure flag, version 1

### Administrative attributes

*Source organisation:* National Health Data Committee

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## Date of commencement of treatment episode for alcohol and other drugs

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*Admin. status:* CURRENT 1/07/2001

### Identifying and definitional attributes

*Knowledgebase ID:* 000430 Version number: 2

*Data element type:* DATA ELEMENT

*Definition:* Date on which a treatment episode for alcohol and other drugs commences.

*Context:* Alcohol and other drug treatment services: Required to identify the commencement of a treatment episode by an alcohol and other drug treatment service.

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

*Data domain:* Valid dates

*Guide for use:* The first date of the treatment episode is the first service contact within the treatment episode when assessment and/or treatment occurs.

*Verification rules:* Must be earlier than or the same as the 'Date of cessation of treatment episode for alcohol and other drugs'.

*Related data:* supersedes previous concept Commencement of treatment, version 1  
relates to the concept Commencement of treatment episode for alcohol and other drugs, version 2

### Administrative attributes

*Source organisation:* Intergovernmental Committee on Drugs NMDS-WG

*National minimum data sets:*

Alcohol and other drug treatment services from 01/07/2000

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## Date of first contact

---

*Admin. status:* CURRENT 1/07/1998

### Identifying and definitional attributes

*Knowledgebase ID:* 000039 Version number: 2

*Data element type:* DATA ELEMENT

*Definition:* The date of first contact with the community nursing service for an episode of care, between a staff member and a person or a person's family.

The definition includes:

- visits made to a person in institutional settings such as liaison visits or discharge planning visits, made in a hospital or residential aged care service with the intent of planning for the future delivery of service at home;
- telephone contacts when these are in lieu of a first home or hospital visit for the purpose of preliminary assessment for care at home;
- visits made to the person's home prior to admission for the purpose of assessing the suitability of the home environment for the person's care.

This applies irrespective of whether the person is present or not.

The definition excludes first visits where the visit objective is not met, such as first visit made where no one is home.

*Context:* To enable analysis of time periods throughout a care episode, especially the pre-admission period and associated activities. This data element enables the capture of the commencement of care irrespective of the setting in which the activities took place.

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

*Data domain:* Valid date

*Verification rules:* This should occur after a previous Date of last contact of a previous care episode and prior to or on the same as Date of first delivery of service.

*Collection methods:* The Date of first contact can be the same as Date of first delivery of service and apply whether a person is entering care for the first time or any subsequent episode. This date should be recorded when it is the same as the first delivery of service date.

*Related data:* supersedes Date of first contact, version 1  
relates to Date of last contact, version 2

### Administrative attributes

*Source organisation:* Australian Council of Community Nursing Services

*Comments:* This item is recommended for use in community services which are funded for liaison or discharge planning positions or provide specialist consultancy or assessment services. Further developments in community care, including casemix and coordinated care will require collection of data relating to resource expenditure across the sector.

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## Date patient presents

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*Admin. status:* CURRENT 1/07/2001

### Identifying and definitional attributes

*Knowledgebase ID:* 000350 Version number: 2

*Data element type:* DATA ELEMENT

*Definition:* The day on which the patient/client presents for the delivery of a service.

*Context:* Admitted patient care:  
Community health care:  
Hospital non-admitted patient care:  
required to identify commencement of a visit and for calculation of waiting times.

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

*Data domain:* Valid dates

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

The time of patient presentation at the Emergency Department is the earliest occasion of being registered clerically or triaged.

The date that the patient presents is not necessarily

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

*Related data:* supersedes previous Date patient presents, version 1  
relates to Admission date, version 4  
relates to Emergency Department waiting time to service delivery, version 1  
relates to Emergency Department waiting time to admission, version 1  
relates to concept Patient presentation at Emergency Department, version 1  
relates to Time patient presents, version 2  
relates to Type of visit to Emergency Department, version 2  
relates to Date of triage, version 1  
relates to Time of triage, version 1  
relates to Triage category, version 1  
relates to Date of commencement of service event, version 2  
relates to Time of commencement of service event, version 2

## **Administrative attributes**

**Source organisation:** National Institution Based Ambulatory Model Reference Group;  
NHDC

**National minimum data sets:**

Emergency Department waiting times from 1/07/1999 to

**Comments:** This data element is required to identify commencement of a visit and for calculation of waiting times. It supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department Waiting Times National Minimum Data Set.

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## Hospital waiting list

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*Admin. status:* CURRENT 1/07/1995

### Identifying and definitional attributes

*Knowledgebase ID:* 000067 Version number: 1

*Data element type:* DATA ELEMENT CONCEPT

*Definition:* A register which contains essential details about patients who have been assessed as needing elective hospital care.

*Context:* Admitted patient care:

### Relational and representational attributes

*Related data:* relates to Patient listing status, version 3  
relates to Waiting list category, version 3

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## Listing date for care

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*Admin. status:* CURRENT 1/07/2001

### Identifying and definitional attributes

*Knowledgebase ID:* 000082 Version number: 3

*Data element type:* DATA ELEMENT

*Definition:* The date on which a hospital or a community health service accepts notification that a patient/client requires care/treatment.

*Context:* Hospital non-admitted patient care:  
Community health care:  
Elective surgery (admitted patient care):

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

*Data domain:* Valid dates

*Guide for use:* The acceptance of the notification by the hospital or community health service is conditional upon the provision of adequate information about the patient and the appropriateness of the patient referral.

For elective surgery, the listing date is the date on which the patient is added to an elective surgery waiting list.

*Related data:* supersedes previous data element Listing date, version 2  
is used in conjunction with Patient listing status, version 3  
is used in conjunction with Scheduled admission date, version 2  
is used in the calculation of Waiting time at a census date, version 1  
is used in the calculation of Waiting time at admission, version 1

### Administrative attributes

*Source organisation:* National Health Data Committee

#### *National minimum data sets:*

Elective surgery waiting times from 1/07/1994 to

*Comments:* The hospital or community health service should only accept a patient onto the waiting list when sufficient information has been provided to fulfil State/Territory, local and national reporting requirements.

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## Mode of admission

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*Admin. status:* CURRENT 1/07/1999

### Identifying and definitional attributes

*Knowledgebase ID:* 000385 Version number: 4

*Data element type:* DATA ELEMENT

*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.

### Relational and representational attributes

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

*Data domain:*

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

*Guide for use:* Code 2 – use this code where a new episode of care is commenced within the same hospital stay.  
Code 3 – use this code for all planned admissions and unplanned admissions (except transfers into the hospital from another hospital).

*Related data:* supersedes Source of referral to acute hospital or private psychiatric hospital, version 3  
supplements the data element Mode of separation, version 3

### Administrative attributes

*Source organisation:* National Health Data Committee

#### *National minimum data sets:*

Admitted patient care from 1/07/2000 to

Admitted patient palliative care from 1/07/2000 to

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## Patient listing status

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*Admin. status:* CURRENT 1/07/1997

### Identifying and definitional attributes

*Knowledgebase ID:* 000120 Version number: 3

*Data element type:* DATA ELEMENT

*Definition:* An indicator of the person's readiness to begin the process leading directly to being admitted to hospital for the awaited procedure. A patient may be 'ready for care' or 'not ready for care'.

### Relational and representational attributes

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

*Data domain:*  
1 Ready for care  
2 Not ready for care

*Guide for use:* 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 admission' and 'Waiting time at a census date'.

*Related data:* relates to concept Hospital waiting list, version 1  
supersedes previous data element Patient listing status, version 2  
used in conjunction with Waiting list category, version 3  
is a qualifier of Category reassignment date, version 2

### Administrative attributes

*Source organisation:* Hospital Access Program Waiting Lists Working Group/Waiting Times Working Group/National Health Data Committee

*National minimum data sets:*

Elective surgery waiting times from 1/07/1994 to

**Comments:**

Only patients ready for care are to be included in the National Minimum Data Set – 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 (data element Category reassignment date).

At the Waiting Times Working Group meeting on 9 September 1996, it was agreed to separate data elements Patient listing status and Clinical urgency as the combination of these items had led to confusion.

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## Patient presentation at Emergency Department

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*Admin. status:* CURRENT 1/07/1998

### Identifying and definitional attributes

*Knowledgebase ID:* 000349 Version number: 1

*Data element type:* DATA ELEMENT CONCEPT

*Definition:* The presentation of a patient at an Emergency Department occurs following the arrival of the patient at the Emergency Department and is the earliest occasion of being:

- registered clerically; or
- triaged

*Context:* Admitted patient care:

### Relational and representational attributes

*Guide for use:* Provided with a service by a treating medical officer or nurse. (In hospital data collection systems, the time and date of the first contact would be selected from the earliest three different recorded times.)

The act of receiving treatment in the Emergency Department is logically preceded by some form of triage event – either formally or informally. For instance, a patient may be so critically ill that they by-pass the formal triage process to receive resuscitative intervention. However, the act of prioritising access to care according to the level of need has still occurred.

### Administrative attributes

*Comments:* This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department Waiting Times National Minimum Data Set.

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## Previous specialised treatment

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*Admin. status:* CURRENT 1/07/1999

### Identifying and definitional attributes

*Knowledgebase ID:* 000139 Version number: 3

*Data element type:* DATA ELEMENT

*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.

### Relational and representational attributes

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

*Data domain:*

- 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
- 5 Unknown/not stated

*Guide for use:* For codes 2–4 Includes 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).

Admitted patients, whose only prior specialised treatment contact was the service contact that referred the patient for admission should be coded as category 1.

*Related data:* supersedes previous data element First admission for psychiatric treatment, version 2  
relates to concept Service contact, version 1

### Administrative attributes

*Source organisation:* National Health Data Committee/National Mental Health Information Strategy Committee

#### *National minimum data sets:*

Admitted patient mental health care from 1/07/2000 to

Admitted patient palliative care from 1/07/2000 to

**Comments:**

This data item was originally developed in the context of mental health admitted patient care data development (originally '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 data 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.

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## Reason for removal from elective surgery waiting list

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*Admin. status:* CURRENT 1/07/2001

### Identifying and definitional attributes

*Knowledgebase ID:* 000142 Version number: 3

*Data element type:* DATA ELEMENT

*Definition:* The reason why a patient is removed from the waiting list.

*Context:* Elective surgery: routine admission for the awaited procedure is only one reason why patients are removed from the waiting list. Each reason for removal provides different information. These data are necessary to augment census and throughput data. For example, after an audit the numbers of patients on a list would be expected to reduce. If an audit were undertaken immediately prior to a census the numbers on the list may appear low and not in keeping with the number of additions to the list and patients admitted from the list.

### Relational and representational attributes

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

*Data domain:*

1	Admitted as an elective patient for awaited procedure in this hospital
2	Admitted as an emergency patient for awaited procedure in this hospital
3	Could not be contacted (includes patients who have died while waiting whether or not the cause of death was related to the condition requiring treatment)
4	Treated elsewhere for awaited procedure
5	Surgery not required or declined
9	Not known

*Guide for use:* Patients undergoing the awaited procedure whilst admitted for another reason are to be coded as code 1.

Code 2 identifies patients who were admitted ahead of their normal position in the queue because the condition requiring treatment deteriorated whilst waiting. Admission as an emergency patient could also be due to other causes such as inappropriate urgency rating, delays in the system, or unpredicted biological variation.

Codes 3–5 provide an indication of the amount of clerical audit of the waiting lists. Code 4 gives an indication of patients treated in other hospitals for the awaited procedure. The procedure may have been performed as an emergency or as an elective procedure.

Code 9 identifies patients removed from the waiting list for reasons unknown.

*Related data:* supersedes previous data element Reason for removal, version 2

### Administrative attributes

*Source organisation:* Hospital Access Program Waiting Lists Working Group/Waiting Times Working Group/National Health Data Committee

*National minimum data sets:*

Elective surgery waiting times from 01/07/1994 to

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## Source of referral to alcohol and other drug treatment service

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*Admin. status:* CURRENT 1/07/2000

### Identifying and definitional attributes

*Knowledgebase ID:* 000444 Version number: 1

*Data element type:* DATA ELEMENT

*Definition:* The source from which the person was transferred or referred care to the alcohol and other drug treatment service.

*Context:* Alcohol and other drug treatment services: Source of referral is important in assisting in the analyses of inter-sectoral patient/client flow and for health care planning.

### Relational and representational attributes

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

*Data domain:*

- 1 Self
- 2 Family member/friend
- 3 General practitioner
- 4 Medical specialist
- 5 Psychiatric hospital
- 6 Other hospital
- 7 Residential community mental health care unit
- 8 Residential alcohol and other drug treatment/care unit
- 9 Other residential community care unit
- 10 Non-residential medical and/or allied health care agency
- 11 Non-residential community mental health care agency or outpatient clinic
- 12 Non-residential alcohol and other drug treatment agency or outpatient clinic
- 13 Other non-residential community health care agency or outpatient clinic
- 14 Other community service agency
- 15 Community based corrections
- 16 Police diversion
- 17 Court diversion
- 18 Other
- 99 Not stated/inadequately described

*Guide for use:*

- 3 General practitioner includes vocationally registered general practitioners, vocationally registered general practitioner trainees and other primary-care medical practitioners in private practice.
- 4 Includes specialists in private practice.
- 5-6 Includes public and private hospitals, hospitals specialising in dental, ophthalmic aids and other specialised medical or surgical care, satellite units managed and staffed by a hospital, Emergency Departments of hospitals, and Mothercraft hospitals. Excludes outpatient clinics (which should be coded to 14-17), Non-residential community health care agencies or outpatient clinics.

**Guide for use:**

- 7-9 Includes settings in which persons reside temporarily at an accommodation unit providing support, non-acute care and other services to people with particular personal, social or behavioural problems. Includes mental health care units for people with severe mental illness or severe psychosocial disability and drug and alcohol residential treatment units.
- 10 Non-residential service centres that operate a range of medical and/or allied health services from a centre-based establishment, including blood donation centres, breast-screening clinics, dental clinics, general medical centres, HIV or AIDS clinics, sexual health clinics; day procedure centres or facilities, Aboriginal medical centres. Excludes any of the above operating from hospital outpatient clinics, which should be coded to 17 Other non-residential community health care agency or outpatient clinic.
- 11-13 Non-residential centre-based establishments providing a range of community-based health services, including community health centres, family planning centres, maternal and child health centres, migrant women's health centres, multipurpose health centres.
- 14 Includes Home and Community Care agencies, Aged Care Assessment Teams, agencies providing care or assistance to persons in their own homes, child care centres/pre-schools or kindergartens, community centres, family support services, domestic violence and incest resource centres or services, Aboriginal cooperatives.

**Administrative attributes***National minimum data sets:*

Alcohol and other drug treatment services

from 1/07/2000 to

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## Source of referral to public psychiatric hospital

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*Admin. status:* CURRENT 1/07/1997

### Identifying and definitional attributes

*Knowledgebase ID:* 000150 Version number: 3

*Data element type:* DATA ELEMENT

*Definition:* Source from which the person was transferred/referred to the public psychiatric hospital.

*Context:* To assist in analyses of intersectoral patient flow and health care planning.

### Relational and representational attributes

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

*Data domain:*

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

*Related data:* supersedes previous Source of referral, version 2  
supplements Mode of separation, version 3

### Administrative attributes

*Source organisation:* National Health Data Committee

#### *National minimum data sets:*

Admitted patient care from 1/07/2000 to

Admitted patient mental health care from 1/07/2000 to

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## Time patient presents

---

*Admin. status:* CURRENT 1/07/2001

### Identifying and definitional attributes

*Knowledgebase ID:* 000351 Version number: 2

*Data element type:* DATA ELEMENT

*Definition:* The time at which the patient presents for the delivery of a service.

*Context:* Admitted patient care:  
Community health care:  
Hospital non-admitted patient care:  
required to identify commencement of a visit and for calculation of waiting times.

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 4 Max. 4 Layout: HHMM

*Data domain:* Expressed as hours and minutes using 24-hour clock

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

The time of patient presentation at the Emergency Department is the earliest occasion of being registered clerically or triaged.

The time that the patient presents is not necessarily

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

*Related data:* supersedes previous Time patient presents, version 1  
relates to Admission time, version 2  
relates to Emergency Department waiting time to service delivery, version 1  
relates to Emergency Department waiting time to admission, version 1  
relates to Date patient presents, version 2  
relates to Date of triage, version 1  
relates to Time of triage, version 1  
relates to Triage category, version 1  
relates to Date of commencement of service event, version 2  
relates to concept Patient presentation at Emergency Department, version 1  
relates to Time of commencement of service event, version 2

## **Administrative attributes**

**Source organisation:** National Institution Based Ambulatory Model Reference Group; NHDC

**National minimum data sets:**

Emergency Department waiting times from 1/07/1999 to

**Comments:** This data element is required to identify commencement of a visit and for calculation of waiting times. It supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department Waiting Times National Minimum Data Set.

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## Type of residential aged care service admission

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*Admin. status:* CURRENT 1/07/1989

### Identifying and definitional attributes

*Knowledgebase ID:* 000172 Version number: 1

*Data element type:* DATA ELEMENT

*Definition:* Type of admission distinguishes respite/crisis care episodes from other residential aged care services episodes.

*Context:* Residential aged care service statistics: this item will assist in analyses of demand for institutional services and planning studies.

### Relational and representational attributes

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

*Data domain:*

- 1 Respite/crisis care (short-term admission, usually in order to give a carer respite from the provision of care)
- 2 Other (continuing care)

*Collection methods:* This item is based on the form NH5, which has been replaced.

### Administrative attributes

*Source organisation:* National minimum data set working parties

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## Type of visit to Emergency Department

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*Admin. status:* CURRENT 1/07/2001

### Identifying and definitional attributes

*Knowledgebase ID:* 000352 Version number: 2

*Data element type:* DATA ELEMENT

*Definition:* The reason the patient presents to the Emergency Department.

*Context:* Hospital non-admitted patient care: Required for analysis of Emergency Department services.

### Relational and representational attributes

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

*Data domain:*

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

*Related data:*

- supersedes Type of visit to Emergency Department, version 2
- relates to Emergency Department waiting time to service delivery, version 1
- relates to Emergency Department waiting time to admission, version 1
- relates to concept Patient presentation at Emergency Department, version 1
- relates to Triage category, version 1

### Administrative attributes

*Source organisation:* National Institution Based Ambulatory Model Reference Group; NHDC

#### *National minimum data sets:*

Emergency Department waiting times from 1/07/1999 to

*Comments:* This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department Waiting Times National Minimum Data Set.

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## Waiting list category

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*Admin. status:* CURRENT 1/01/1995

### Identifying and definitional attributes

*Knowledgebase ID:* 000176 Version number: 3

*Data element type:* DATA ELEMENT

*Definition:* The type of elective hospital care that a patient requires.

*Context:* Admitted patients: hospitals maintain waiting lists which may include patients awaiting hospital care other than elective surgery – for example, dental surgery and oncology treatments. This item is necessary to distinguish patients awaiting elective surgery (code 1) from those awaiting other types of elective hospital care (code 2).

The waiting period for patients awaiting transplant or obstetric procedures is largely independent of system resource factors.

### Relational and representational attributes

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

*Data domain:*

1	Elective surgery
2	Other

*Guide for use:* Elective surgery comprises elective care where the procedures required by patients are listed in the surgical operations section of the Medicare Benefits Schedule, with the exclusion of specific procedures frequently done by non-surgical clinicians.

Elective care is care that, in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least twenty-four hours.

Patients awaiting the following procedures should be classified as Code 2 – other:

- organ or tissue transplant procedures
- procedures associated with obstetrics (e.g. elective caesarean section, cervical suture)
- cosmetic surgery, i.e. when the procedure will not attract a Medicare rebate
- biopsy of:
  - kidney (needle only)
  - lung (needle only)
  - liver and gall bladder (needle only)
- bronchoscopy (including fibre-optic bronchoscopy)
- peritoneal renal dialysis; haemodialysis
- colonoscopy
- endoscopic retrograde cholangio-pancreatography (ERCP)
- endoscopy of:
  - biliary tract
  - oesophagus
  - small intestine
  - stomach

**Guide for use  
(continued):**

- endovascular interventional procedures
- gastroscopy
- miscellaneous cardiac procedures
- oesophagoscopy
- panendoscopy (except when involving the bladder)
- proctosigmoidoscopy
- sigmoidoscopy
- anoscopy
- urethroscopy and associated procedures
- dental procedures not attracting a Medicare rebate
- other diagnostic and non-surgical procedures.

These procedure terms are also defined by the ICD-10-AM (International Statistical Classification of Diseases and Related Health Problems – Tenth Revision – Australian Modification (2nd edition) National Centre for Classification in Health, Sydney) codes which are listed under Comments below. This coded list is the recommended, but optional, method for determining whether a patient is classified as requiring elective surgery or other care.

All other elective surgery should be included in waiting list Code 1 – elective surgery.

**Related data:**

relates to concept Elective care, version 1

supersedes previous data element Waiting list category – ICD-9-CM code, version 2

used in conjunction with Patient listing status, version 3

is supplemented by the data element Indicator procedure, version 3

**Administrative attributes**

**Source document:** International Statistical Classification of Diseases and Related Health Problems – Tenth Revision – Australian Modification (2nd edition) National Centre for Classification in Health, Sydney.

**Source organisation:** Hospital Access Program Waiting Lists Working Group/Waiting Times Working Group/National Health Data Committee

**National minimum data sets:**

Elective surgery waiting times

from 1/07/1994 to

**Comments:**

The table of ICD-10-AM procedure codes was prepared by the National Centre for Classification in Health. Some codes were excluded from the list on the basis that they are usually performed by non-surgeon clinicians.

A more extensive and detailed listing of procedure descriptors is under development. This will replace the list in the Guide for use above, to facilitate more readily the identification of the exclusions when the list of codes is not used.

**ICD-10-AM CODES FOR THE EXCLUDED PROCEDURES:**

Organ or tissue transplant

90172-00 [555] 30204-00 [659] 90204-01 [659] 13706-08 [802] 90172-01 [555]  
 90324-00 [981] 90205-00 [660] 36503-00 [1057] 13706-00 [802] 13706-06 [802]  
 13706-07 [802] 13700-00 [801] 36503-01 [1057] 30375-21 [817] 90317-00 [954]  
 90324-00 [981] 14203-01 [1906]

**Comments (continued):** Procedures associated with obstetrics

16511-00 [1274] 16512-00 [1274] 90467-00 [1336] 90469-00 [1338] 90469-01 [1338]  
 90470-00 [1339] 90468-00 [1337] 90468-01 [1337] 90472-00 [1343] 90470-02 [1339]  
 90470-01 [1339] 90470-04 [1339] 90470-03 [1339] 90468-02 [1337] 90468-04 [1337]  
 90478-00 [1334] 90477-00 [1343] 90465-03 [1342] 90477-00 [1343] 90466-00 [1335]  
 90466-01 [1335] 90466-02 [1335] 90466-01 [1335] 90471-01 [1342] 90471-02 [1342]  
 90471-03 [1342] 16564-00 [1345] 16564-01 [1345] 90465-04 [1334] 90471-05 [1342]  
 90471-04 [1342] 90468-05 [1337] 90465-00 [1334] 90465-01 [1334] 90465-02 [1334]  
 90471-06 [1342] 90476-00 [1343] 90471-00 [1342] 90473-00 [1343] 90474-00 [1343]  
 90475-00 [1343] 90477-00 [1343] 16567-00 [1347] 16520-01 [1340] 16520-02 [1340]  
 16520-03 [1340] 16520-00 [1340] 16603-00 [1795] 16627-00 [1330] 90461-00 [1330]  
 16600-00 [1330] 16618-00 [1330] 16609-00 [1330] 16612-00 [1330] 16615-00 [1330]  
 16624-00 [1331] 90486-00 [1333] 90486-01 [1333] 90486-02 [1333] 90460-00 [1330]  
 16514-00 [1341] 16514-01 [1341] 16606-00 [1330] 90464-00 [1332] 90482-00 [1345]  
 90463-00 [1330] 16621-00 [1330] 16571-00 [1344] 90485-00 [1344] 90480-00 [1344]  
 90480-01 [1344] 90481-00 [1344] 16573-00 [1344] 90483-00 [1347] 16567-00 [1347]  
 90484-00 [1347] 90484-02 [1347] 90484-01 [1347] 16570-01 [1346] 16570-00 [1346]

Biopsy (needle) of:

Kidney 36561-00 [1046]

Lung 38412-00 [550]

liver and gall bladder 30409-00 [953] 30412-00 [953] 90319-01 [951] 30094-04 [964]

Bronchoscopy

41889-00 [543] 41892-00 [544] 41904-00 [546] 41764-02 [416] 41895-00 [544]  
 41764-04 [532] 41892-01 [545] 41901-00 [545] 41846-00 [520] 41898-00 [543]  
 41898-01 [544] 41889-01 [543] 41849-00 [520] 41764-03 [520] 41855-00 [520]

Peritoneal renal dialysis

13100-06 [1060] 13100-07 [1060] 13100-08 [1060] 13100-00 [1059]

Endoscopy of biliary tract, ERCP

30484-00 [957] 30484-01 [957] 30484-02 [974] 30494-00 [971] 30452-00 [971]  
 30491-00 [958] 30491-01 [963] 30485-00 [958] 30485-01 [963] 30452-01 [963]  
 30450-00 [958] 30452-02 [959] 30485-01 [959] 90349-00 [975]

Endoscopy of oesophagus

30473-03 [850] 30473-04 [861] 41822-00 [861] 30478-11 [856] 41819-00 [862]  
 30478-10 [852] 30478-13 [861] 41816-00 [850] 41822-00 [861] 41825-00 [852]  
 30478-12 [856] 41831-00 [862] 30478-12 [856] 30490-00 [853] 30479-00 [856]

Endoscopy of small intestine

30473-00 [1005] 30473-01 [1008] 32095-00 [891] 30569-00 [894] 30478-04 [1008]  
 30478-02 [1007] 30478-03 [1007] 30478-00 [1006] 30568-00 [893]

Endoscopy of stomach

30473-00 [1005] 30476-03 [874] 30473-01 [1008] 30478-01 [1007] 30478-04 [1008]  
 30478-02 [1007] 30478-03 [1007] 30478-00 [1006] 30473-02 [1005]

Endoscopy of large intestine, colonoscopy, proctosigmoidoscopy, sigmoidoscopy, anoscopy

32090-00 [905] 32090-01 [911] 90315-00 [943] 90308-00 [908] 32093-00 [911]  
 32084-00 [905] 32084-01 [911] 30479-02 [908] 32087-00 [911] 30479-01 [930]  
 32075-00 [904] 32075-01 [910] 32078-00 [910] 32081-00 [910] 32072-00 [904]  
 32072-01 [910] 32171-00 [938]

**Comments (continued):** Miscellaneous cardiac

38200-00 [667] 38203-00 [667] 38206-00 [667] 38212-00 [665] 38209-00 [665]  
38278-00 [648] 38278-01 [648] 38284-00 [648] 38470-00 [649] 38473-00 [649]  
38278-02 [654] 38456-07 [654] 90203-00 [654] 38284-00 [654] 38256-00 [647]  
38256-01 [647] 38256-02 [647] 90202-00 [649] 90219-00 [663] 38253-00 [652]  
38253-01 [650] 38253-02 [650] 38253-03 [650] 38253-04 [650] 38253-05 [650]  
38253-06 [650] 38253-07 [651] 38253-08 [651] 38253-09 [651] 38253-10 [651]  
38253-11 [655] 38253-12 [655] 35315-00 [758] 35315-01 [758] 35324-00 [740]  
38603-00 [642] 38600-00 [642]

Endovascular interventional

35304-01 [670] 35305-00 [670] 35310-00 [971] 35310-01 [671] 35310-03 [671]  
35310-04 [671] 35310-02 [671] 35310-05 [671] 34524-00 [694] 90220-00 [738]  
35304-00 [670] 32500-01 [722] 32500-00 [722]

Urethroscopy

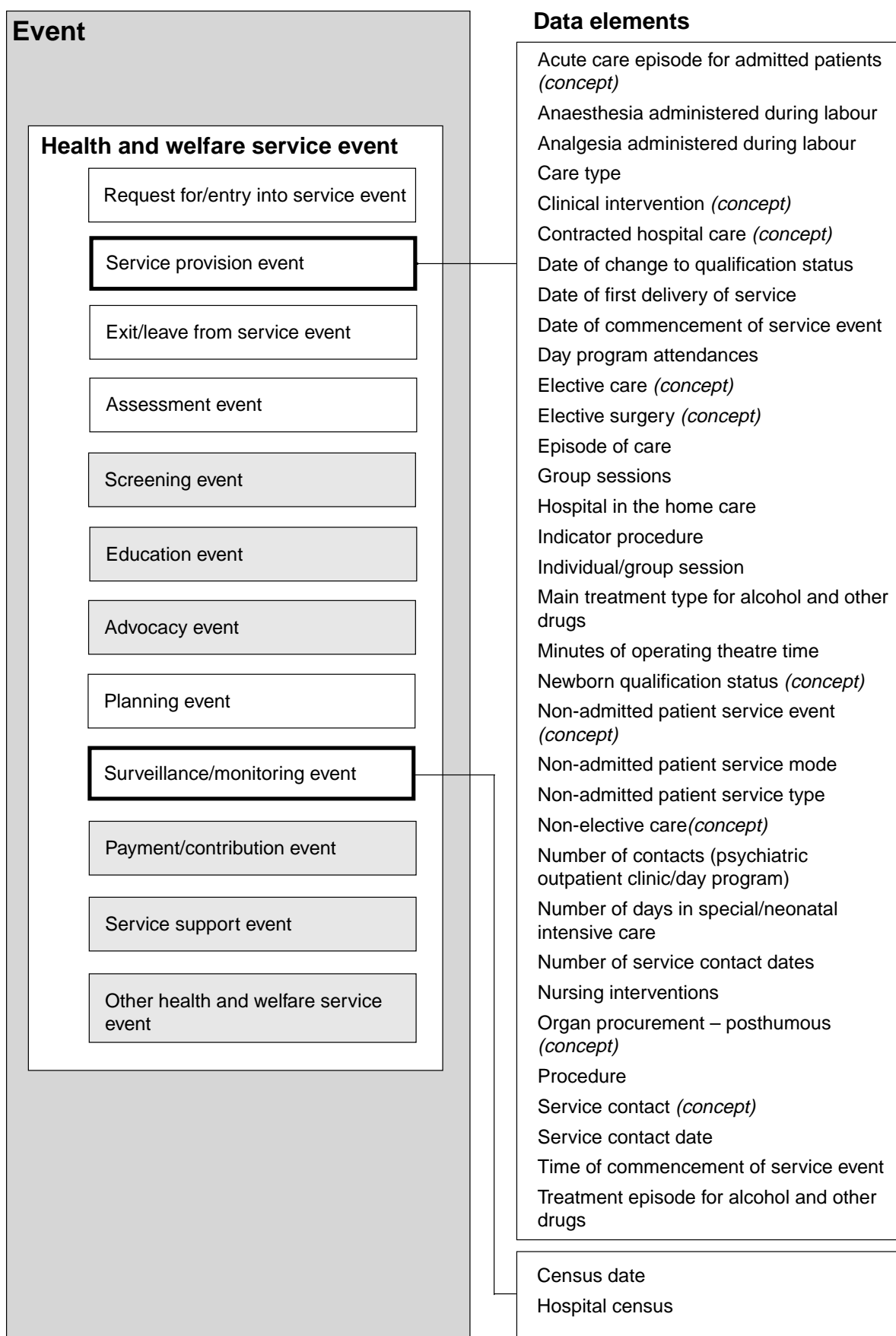
36800-00 [1089] 36800-01 [1089] 37011-00 [1092] 37008-01 [1092] 37008-00 [1092]  
37315-00 [1111] 37315-01 [1115] 37318-01 [1115] 36815-01 [1115] 37854-00 [1115]  
37318-04 [1116] 35527-00 [1115]

Dental-Blocks [450] to [490]

Other diagnostic and non-surgical

90347-01 [983] 90760-00 [1780] 90767-00 [1780] 13915-00 [1780] 13918-00 [1780]  
13921-00 [1780] 13927-00 [1780] 13939-00 [1780] 13942-00 [1780] 90768-00 [1780]  
Blocks [1820] to 1939], [1940] to [2016]

# National Health Information Model entity



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## Acute care episode for admitted patients

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*Admin. status:* CURRENT 1/07/1995

### Identifying and definitional attributes

*Knowledgebase ID:* 000004 Version number: 1

*Data element type:* DATA ELEMENT CONCEPT

*Definition:* An episode of acute care for an admitted patient is one in which the principal clinical intent is to do one or more of the following:

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

*Context:* Admitted patient care:

### Relational and representational attributes

*Related data:* relates to Care type, version 4

### Administrative attributes

*Source organisation:* National Health Data Committee

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## Anaesthesia administered during labour

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*Admin. status:* CURRENT 1/07/1996

### Identifying and definitional attributes

*Knowledgebase ID:* 000013 Version number: 1

*Data element type:* DATA ELEMENT

*Definition:* Anaesthesia administered for the operative delivery of the baby (caesarean, forceps or vacuum extraction).

*Context:* Perinatal: anaesthetic use may influence the duration of labour, may affect the health status of the baby at birth and is an indicator of obstetric intervention.

### Relational and representational attributes

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

*Data domain:*

1	None
2	Local anaesthetic to perineum
3	Pudendal
4	Epidural or caudal
5	Spinal
6	General
8	Other
9	Not stated

*Guide for use:* If more than one agent is used, select the largest number (excluding 8 or 9) as this is how the data are tabulated.

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

### Administrative attributes

*Source organisation:* National Perinatal Data Development Committee

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## Analgesia administered during labour

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*Admin. status:* CURRENT 1/07/1996

### Identifying and definitional attributes

*Knowledgebase ID:* 000014 Version number: 1

*Data element type:* DATA ELEMENT

*Definition:* Agents administered to the mother by injection or inhalation to relieve pain during labour and delivery.

*Context:* Perinatal: analgesia use may influence the duration of labour, may affect the health status of the baby at birth and is an indicator of obstetric intervention.

### Relational and representational attributes

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

*Data domain:*

1	None
2	Nitrous oxide
3	Intra-muscular narcotics
4	Epidural/caudal
5	Spinal
8	Other
9	Not stated

*Guide for use:* If more than one agent is used, select the largest number (excluding 8 or 9) as this is how the data will be tabulated.

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

### Administrative attributes

*Source organisation:* National Perinatal Data Development Committee

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## Care type

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*Admin. status:* CURRENT 1/07/2000

### Identifying and definitional attributes

*Knowledgebase ID:* 000168 Version number: 4

*Data element type:* DATA ELEMENT

*Definition:* The care type defines the overall nature of a clinical service provided to an admitted patient during an episode of care (admitted care), or the type of service provided by the hospital for boarders or posthumous organ procurement (other care).

*Context:* Admitted patient care: and hospital activity. For admitted patients, the type of care received will determine the appropriate casemix classification employed to classify the episode of care.

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 3 Max. Layout: (N)N.N

*Data domain:* Admitted care:

- 1.0 Acute care
- 2.0 Rehabilitation care
- 2.1 Rehabilitation care delivered in a designated unit (optional)
- 2.2 Rehabilitation care according to a designated program (optional)
- 2.3 Rehabilitation care is the principal clinical intent (optional)
- 3.0 Palliative care
- 3.1 Palliative care delivered in a designated unit (optional)
- 3.2 Palliative care according to a designated program (optional)
- 3.3 Palliative care is the principal clinical intent (optional)
- 4.0 Geriatric evaluation and management
- 5.0 Psychogeriatric care
- 6.0 Maintenance care
- 7.0 Newborn care
- 8.0 Other admitted patient care

Other care:

- 9.0 Organ procurement – posthumous
- 10.0 Hospital boarder

*Guide for use:* Persons with mental illness may receive any one of the care types (except newborn and organ procurement). Classification depends on the principal clinical intent of the care received. Admitted care can be one of the following:

- 1.0 Acute care is care in which the clinical intent or treatment goal is to:
- manage labour (obstetric);
  - cure illness or provide definitive treatment of injury;
  - perform surgery;
  - relieve symptoms of illness or injury (excluding palliative care);
  - reduce severity of an illness or injury;

**Guide for use  
(continued):**

- protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function; and/or
- perform diagnostic or therapeutic procedures.

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

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

Optional categories

2.1 A designated rehabilitation care unit (code 2.1) is a dedicated ward or unit (and can be a stand-alone unit) that receives identified funding for rehabilitation care and/or primarily delivers rehabilitation care.

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

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

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

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

Optional categories

3.1 A designated palliative care unit (code 3.1) is a dedicated ward or unit (and can be a stand-alone unit) that receives identified funding for palliative care and/or primarily delivers palliative care.

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

*Guide for use  
(continued):*

3.3 Palliative care as principal clinical intent (code 3.3) occurs when the patient is primarily managed by a medical practitioner who is a specialist in palliative care or when, in the opinion of the treating medical practitioner, the care provided is palliative care even if the doctor is not a palliative care specialist. The exception to this is when the medical practitioner is providing care within a designated unit or a designated program, in which case code 3.1 or 3.2 should be used, respectively. For example, code 3.3 would apply to a patient dying of cancer who was being treated in a geriatric ward without specialist input by palliative care staff.

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

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

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

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

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

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

- patients who turn 10 days of age and do not require clinical care are separated and, if they remain in the hospital, are designated as boarders;
- patients who turn 10 days of age and require clinical care continue in a newborn episode of care until separated.
- patients aged less than 10 days and not admitted at birth (e.g. transferred from another hospital) are admitted with newborn care type;
- patients aged greater than 9 days not previously admitted (e.g. transferred from another hospital) are either boarders or admitted with an acute care type;

**Guide for use  
(continued):**

- within a newborn episode of care, until the baby turns 10 days of age, each day is either a qualified or unqualified day.
- a newborn is qualified when it meets at least one of the criteria detailed in Newborn qualification status.

Within a newborn episode of care, each day after the baby turns 10 days of age is counted as a qualified patient day.

Newborn qualified days are equivalent to acute days and may be denoted as such.

8.0 Other admitted patient care is care where the principal clinical intent does not meet the criteria for any of the above.

Other care can be one of the following:

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

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

(b) Hospital boarder is a person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care.

Hospital boarders are not admitted to the hospital. However, a hospital may register a boarder. Babies in hospital at age 9 days or less cannot be boarders. They are admitted patients with each day of stay deemed to be either qualified or unqualified.

**Related data:**

supersedes previous data element Type of episode of care, version 3

used in conjunction with Newborn qualification status, version 2

used in conjunction with Number of (qualified) days for newborns, version 2

**Administrative attributes**

**Source organisation:** National Health Data Committee

**National minimum data sets:**

Admitted patient care from 1/07/2000 to

Admitted patient mental health care from 1/07/2000 to

Admitted patient palliative care from 1/07/2000 to

**Comments:**

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

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## Clinical intervention

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*Admin. status:* CURRENT 1/07/1999

### Identifying and definitional attributes

*Knowledgebase ID:* 000399 Version number: 1

*Data element type:* DATA ELEMENT CONCEPT

*Definition:* An intervention carried out to improve, maintain or assess the health of a person, in a clinical situation.

Clinical interventions include invasive and non-invasive procedures, and cognitive interventions.

Invasive:

(a) Therapeutic interventions where there is a disruption of the epithelial lining generally, but not exclusively, with an implied closure of an incision (e.g. operations such as cholecystectomy or administration of a chemotherapeutic drug through a vascular access device);

(b) Diagnostic interventions where an incision is required and/or a body cavity is entered (e.g. laparoscopy with/without biopsy, bone marrow aspiration).

Non-invasive:

Therapeutic or diagnostic interventions undertaken without disruption of an epithelial lining (e.g. lithotripsy, hyperbaric oxygenation; allied health interventions such as hydrotherapy; diagnostic interventions not requiring an incision or entry into a body part such as pelvic ultrasound, diagnostic imaging).

Cognitive:

An intervention which requires cognitive skills such as evaluating, advising, planning (e.g. dietary education, physiotherapy assessment, crisis intervention, bereavement counselling).

*Context:* Health services: Information about the surgical and non-surgical interventions provides the basis for analysis of health service usage, especially in relation to specialised resources, for example theatres and equipment or human resources.

### Administrative attributes

*Source organisation:* National Health Data Committee

*Comments:* Classification and coding systems for procedures include the International Statistical Classification of Diseases and Related Health Problems – Tenth Revision – Australian Modification (2nd edition), (ICD-10-AM) and the International Classification of Primary Care (1987).

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## Contracted hospital care

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*Admin. status:* CURRENT 1/07/2000

### Identifying and definitional attributes

*Knowledgebase ID:* 000337 Version number: 1

*Data element type:* DATA ELEMENT CONCEPT

*Definition:* Contracted hospital care is provided to a patient under an agreement between a purchaser of hospital care (contracting hospital or external purchaser) and a provider of an admitted or non-admitted service (contracted hospital).

*Context:* Admitted patient care:

### Relational and representational attributes

*Data domain:* Valid dates

*Guide for use:* Related contracted hospital care data items should only be completed where services are provided which represent some, but not all of the contracted hospital's total services. It is not necessary to complete contracted hospital care data items where all of the hospital services are contracted by a health authority, e.g. privately owned and/or operated public hospitals.

Contracted hospital care must involve all of the following:

- a purchaser, which can be a public or private hospital, or a health authority (Department or Region) or another external purchaser; and
- a contracted hospital, which can be a public or private hospital or day procedure centre; and
- the purchaser paying the contracted hospital for the contracted service. Thus, services provided to a patient in a separate facility during their episode of care, where the patient is directly responsible for payment of this additional service, are not considered contracted services for reporting purposes; and
- the patient being physically present in the contracted hospital for the provision of the contracted service.

Thus, pathology or other investigations performed at another location on specimens gathered at the contracting hospital would not be considered contracted services for reporting purposes.

Allocation of diagnosis and procedure codes should not be affected by the contract status of an episode: the Australian Coding Standards should be applied when coding all episodes. In particular, procedures which would not otherwise be coded should not be coded solely because they were performed at another hospital under contract.

Procedures performed by a health care service (i.e. not a recognised hospital) should be coded if appropriate but are not considered to be contracted hospital procedures.

Any DRG derived for episodes involving contracted hospital care, should reflect the total treatment provided (all patient days and procedures), even where part of the treatment was provided under contract by another hospital.

**Related data:**

- relates to Contract type, version 1
- relates to Contract role, version 1
- relates to Contract establishment identifier, version 3
- relates to Contracted care commencement date, version 1
- relates to Contracted care completion date, version 1
- relates to Total contract patient days, version 1
- relates to Contract procedure flag, version 1

**Administrative attributes**

**Source organisation:** National Health Data Committee

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## Date of change to qualification status

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*Admin. status:* CURRENT 1/07/1998

### Identifying and definitional attributes

*Knowledgebase ID:* 000342 Version number: 1

*Data element type:* DATA ELEMENT

*Definition:* The date, within a newborn episode of care, on which the newborn's Qualification status changes from acute (qualified) to unqualified or vice versa.

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

*Data domain:* Valid date

*Guide for use:* Record the date or dates on which the newborn's Qualification Status changes from acute (qualified) to unqualified or vice versa.  
If more than one change of qualification status occurs on a single day, the day is counted against the final qualification status.

*Verification rules:* Must be greater than or equal to admission date

*Related data:* used in conjunction with Admitted patient, version 3  
used in conjunction with Care type, version 4  
used in conjunction with Newborn qualification status, version 2  
is used in the calculation of Number of qualified days for newborns, version 2

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## Date of first delivery of service

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*Admin. status:* CURRENT 1/07/1998

### Identifying and definitional attributes

*Knowledgebase ID:* 000038 Version number: 2

*Data element type:* DATA ELEMENT

*Definition:* The date of first delivery of service to a person in a non-institutional setting.

The definition excludes:

- visits made to persons in institutional settings such as liaison visits or discharge planning visits, made in a hospital or residential aged care service, with the intent of planning for the future delivery of community-based services;
- first visits where there is no contact with the person, such as a first visit where no-one is at home.
- telephone, letter or other such contacts made with the person prior to the first home visit.

In situations where the first delivery of service determines that no future visit needs to be made, the Date of first Delivery of service and the Date of last delivery of service will be the same.

*Context:* The Date of first delivery of service is used for the analysis of time periods within a care episode and to locate that episode in time. The date relates to the first delivery of formal services within the community setting.

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

*Data domain:* Valid dates

*Verification rules:* This date may occur on the same day or prior to the Date of last delivery of service, but must never occur after that date within the current episode of care. The date may be the same as the Date of first contact.

*Collection methods:* As long as contact is made with the person in a non-institutional setting, the Date of first delivery of service must be recorded. Normally this will be the first home or clinic visit and is the date most often referred to in a service agency as the admission. This date applies whether a person is being admitted for the first time, or is being re-admitted for care.

*Related data:* supersedes previous Date of first community nursing visit, version 1  
relates to Date of first delivery of service, version 2

### Administrative attributes

*Source organisation:* Australian Council of Community Nursing Services

**Comments:**

This date marks the most standard event, which occurs at the beginning of an episode of care in community setting. It should not be confused with the Date of first contact with a community nursing service; although they could be the same, the dates for both items must be recorded. Agencies providing hospital in the Home services should develop their own method of distinguishing between the period the person remains a formal patient of the hospital, with funding to receive services at home, and the discharge of the person into the care of the community service.

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## Date of commencement of service event

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*Admin. status:* CURRENT 1/07/2001

### Identifying and definitional attributes

*Knowledgebase ID:* 000356 Version number: 2

*Data element type:* DATA ELEMENT

*Definition:* The day on which the delivery of a service commences. The service is defined as commencing when a health care professional first takes responsibility for the patient/client's care.

*Context:* Hospital non – Admitted patient care:  
Community health care.

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

*Data domain:* Valid dates

*Guide for use:* For the Emergency Department the date of triage is recorded separately. In an Emergency Department the service event commences when the medical officer (or, if no medical officer is on duty in the Emergency Department, a treating nurse) provides treatment or diagnostic service. The commencement of a service event does not include contact associated with triage.

*Related data:* supersedes Date of service event, version 1  
relates to Emergency Department waiting time to service delivery, version 1  
relates to Emergency Department waiting time to admission, version 1  
relates to concept Patient presentation at Emergency Department, version 1  
relates to Time of commencement of service event, version 2  
relates to Date of triage, version 1  
relates to Time of triage, version 1  
relates to Date patient presents, version 2  
relates to Time patient presents, version 2

### Administrative attributes

*Source organisation:* National Institution Based Ambulatory Model Reference Group; NHDC

*National minimum data sets:*

Emergency Department waiting times from 1/07/1999 to

*Comments:* This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department Waiting Times National Minimum Data Set.

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## Day program attendances

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*Admin. status:* CURRENT 1/07/1989

### Identifying and definitional attributes

*Knowledgebase ID:* 000211 Version number: 1

*Data element type:* DERIVED DATA ELEMENT

*Definition:* A count of the number of patient/client visits to day centres. Each individual is to be counted once for each time they attend a day centre. Where an individual is referred to another section of the hospital/centre and returns to the day centre after treatment only one visit is to be recorded.

*Context:* Required to measure adequately non-admitted patient services in psychiatric hospitals and alcohol and drug hospitals.

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 1 Max. 5 Layout: NNNNN

*Data domain:* Number of attendances

### Administrative attributes

*Source organisation:* National minimum data set working parties

*Comments:* Difficulties were envisaged in using the proposed definitions of an individual or group occasion of service for clients attending psychiatric day care centres. These individuals may receive both types of services during a visit to a centre.

This data element is derived from data elements that are not currently specified in the National Health Data Dictionary, but which are recorded in various ways by hospitals and/or outpatient departments. Examples include identifiers of individual consultations/visits, diagnostic tests, etc. Further specification/development of these data elements is expected as part of the National Institution Based Ambulatory Care Modelling (NIBAM) Project.

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## Elective care

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*Admin. status:* CURRENT 1/07/1995

### Identifying and definitional attributes

*Knowledgebase ID:* 000348 Version number: 1

*Data element type:* DATA ELEMENT CONCEPT

*Definition:* Care that, in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least twenty-four hours.

*Context:* Admitted patient care:

### Relational and representational attributes

*Related data:* relates to Waiting list category, version 3

### Administrative attributes

*Source organisation:* Hospital Access Program Waiting List Working Group/National Health Data Committee

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## Elective surgery

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*Admin. status:* CURRENT 1/07/1995

### Identifying and definitional attributes

*Knowledgebase ID:* 000046 Version number: 1

*Data element type:* DATA ELEMENT CONCEPT

*Definition:* Elective care where the procedures required by patients are listed in the surgical operations section of the Medicare benefits schedule book, with the exclusion of specific procedures frequently done by non-surgical clinicians.

*Context:* Admitted patient care:

### Relational and representational attributes

*Related data:* relates to Waiting list category, version 3

### Administrative attributes

*Source organisation:* Hospital Access Program Waiting List Working Group/National Health Data Committee

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## Episode of care

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*Admin. status:* CURRENT 1/07/2000

### Identifying and definitional attributes

*Knowledgebase ID:* 000445 Version number: 1

*Data element type:* DATA ELEMENT CONCEPT

*Definition:* The period of admitted patient care between a formal or statistical admission and a formal or statistical separation, characterised by only one care type.

*Context:* Admitted patient care:

### Relational and representational attributes

*Guide for use:* This treatment and/or care provided to a patient during an episode of care can occur in hospital and/or in the person's home (for hospital-in-the-home patients).

*Related data:*

- relates to Care type, version 4
- relates to concept Admitted patient, version 3
- relates to Separation date, version 5
- relates to concept Admission date, version 4
- relates to concept Admission, version 3
- relates to concept Separation, version 3

### Administrative attributes

*Source organisation:* National Health Data Committee

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## Group sessions

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*Admin. status:* CURRENT 1/07/1989

### Identifying and definitional attributes

*Knowledgebase ID:* 000210 Version number: 1

*Data element type:* DERIVED DATA ELEMENT

*Definition:* The number of groups of patients/clients receiving services. Each group is to count once, irrespective of size or the number of staff providing services.

*Context:* The resources required to provide services to groups of patients are different from those required to provide services to an equivalent number of individuals. Hence services to groups of non-admitted patients or outreach clients should be counted separately from services to individuals.

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 1 Max. 6 Layout: NNNNNN

*Data domain:* Number of groups receiving services

*Collection methods:* At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.

### Administrative attributes

*Source organisation:* National minimum data set working parties

*National minimum data sets:*

Public hospital establishments from 1/07/2000 to

*Comments:* This data element is derived from data elements that are not currently specified in the National Health Data Dictionary, but which are recorded in various ways by hospitals and/or outpatient departments. Examples include identifiers of individual consultations/visits, diagnostic tests, etc.

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## Hospital in the home care

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*Admin. status:* DRAFT 1/07/2001

### Identifying and definitional attributes

*Knowledgebase ID:* 000633 Version number: 1

*Data element type:* DATA ELEMENT CONCEPT

*Definition:* Provision of care to hospital admitted patients in their place of residence as a substitute for hospital accommodation. Place of residence may be permanent or temporary.

*Context:* Admitted patient care:

### Relational and representational attributes

*Guide for use:* The criteria for inclusion as hospital in the home include but are not limited to:

- without hospital in the home care being available patients would be accommodated in the hospital;
- the treatment forms all or part of an episode of care for an admitted patient (as defined in the Admitted patient data element concept);
- the hospital medical record is maintained for the patient; and
- there is adequate provision for crisis care.

Selection criteria for the assessment of suitable patients include but are not limited to:

- the hospital deems the patient requires health care professionals funded by the hospital to take an active part in their treatment;
- the patient does not require continuous 24 hour assessment, treatment or observation;
- the patient agrees to this form of treatment;
- the patient's place of residence is safe and has carer support available;
- the patient's place of residence is accessible for crisis care; and
- the patient's place of residence has adequate communication facilities and access to transportation.

*Related data:* relates to concept Admitted patient, version 3  
relates to concept Episode of care, version 1

### Administrative attributes

*Source organisation:* National Health Data Committee

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## Indicator procedure

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*Admin. status:* CURRENT 1/07/2001

### Identifying and definitional attributes

*Knowledgebase ID:* 000073 Version number: 3

*Data element type:* DATA ELEMENT

*Definition:* An indicator procedure is a procedure which is of high volume, and is often associated with long waiting periods.

*Context:* Waiting list statistics for indicator procedures give a specific indication of performance in particular areas of elective care provision.

It is not always possible to code all elective surgery procedures at the time of addition to the waiting list. Reasons for this include that the surgeon may be uncertain of the exact procedure to be performed, and that the large number of procedures possible and lack of consistent nomenclature would make coding errors likely. Furthermore, the increase in workload for clerical staff may not be acceptable. However, a relatively small number of procedures account for the bulk of the elective surgery workload. Therefore, a list of common procedures with a tendency to long waiting times is useful.

Waiting time statistics by procedure are useful to patients and referring doctors. In addition, waiting time data by procedure assists in planning and resource allocation, audit and performance monitoring.

### Relational and representational attributes

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

*Data domain:*

- 01 Cataract extraction (includes: Intracapsular crystalline lens extraction, Extracapsular crystalline lens extraction by aspiration alone, Extracapsular crystalline lens extraction by phacoemulsification, Extracapsular crystalline lens extraction by mechanical phacofragmentation, Other extracapsular crystalline lens extraction, Other extraction of crystalline lens, Removal of juvenile cataract, Other application, insertion or removal procedures on lens)
- 02 Cholecystectomy (includes: Laparoscopic cholecystectomy, Cholecystectomy with choledochotomy, Cholecystectomy with choledochotomy and biliary intestinal anastomosis)
- 03 Coronary artery bypass graft
- 04 Cystoscopy (includes: Cystoscopy through artificial stoma, Endoscopic biopsy of bladder)
- 05 Haemorrhoidectomy (includes: Sclerotherapy for haemorrhoids, Rubber band ligation of haemorrhoids, Destruction of haemorrhoids, haemorrhoidectomy)
- 06 Hysterectomy (includes: Abdominal hysterectomy, Vaginal Hysterectomy, Pelvic exenteration)
- 07 Inguinal herniorrhaphy (includes: Repair of inguinal hernia, Repair of incarcerated, obstructed or strangulated hernia)
- 08 Myringoplasty
- 09 Myringotomy (includes: Myringotomy with insertion of tube)

<b>Data domain (continued):</b>	10	Prostatectomy (includes: Transurethral prostatectomy, Other closed prostatectomy, Open prostatectomy, Endoscopic destruction of prostatic lesion, Endoscopic resection of prostatic lesion)
	11	Septoplasty (includes: Septoplasty, Septoplasty with submucous resection of nasal septum)
	12	Tonsillectomy (includes: Tonsillectomy without adenoidectomy, Tonsillectomy with adenoidectomy)
	13	Total hip replacement (includes: Total arthroplasty of hip (unilateral/bilateral), Revision of total arthroplasty of hip, Revision of total arthroplasty of hip with bone graft or allograft)
	14	Total knee replacement (includes: Total arthroplasty of knee (unilateral/bilateral), Total arthroplasty of knee with bone graft to femur or tibia, Revision of total arthroplasty of knee)
	15	Varicose veins stripping and ligation (includes: Interruption of sapheno-femoral or sapheno-popliteal junction varicose veins, Other destruction procedures on veins)
	16	Not applicable

**Guide for use:** The procedure terms are described using descriptive terms (above) and ICD-10-AM procedure codes (as listed in the Comments below). Either list may be used to determine if a procedure is an indicator procedure.

Where a patient is awaiting more than one indicator procedure, all codes should be listed. This is because the intention is to count procedures rather than patients in this instance. These are planned procedures for the waiting list, not what is actually performed during hospitalisation.

**Verification rules:** Zero filled, right justified.

**Related data:** supersedes previous Indicator procedure – ICD-9-CM code, version 2  
supplements Waiting list category, version 3  
is used in conjunction with Procedure, version 5

## Administrative attributes

**Source organisation:** National Health Data Committee

**National minimum data sets:**

Elective surgery waiting times from 01/07/1994 to

**Comments:** The list of indicator procedures may be reviewed from time to time. Some health authorities already code a larger number of waiting list procedures.

The following is a list of ICD-10-AM codes, for the indicator procedures:

Cataract extraction:

42698-00 [195] 42702-00 [195] 42702-01 [195] 42698-01 [196] 42702-02 [196]  
42702-03 [196] 42698-02 [197] 42702-04 [197] 42702-05 [197] 42698-03 [198]  
42702-06 [198] 42702-07 [198] 42698-04 [199] 42702-08 [199] 42702-09 [199]  
42731-01 [200] 42698-05 [200] 42702-10 [200] 42734-00 [201] 42788-00 [201]  
42719-00 [201] 42731-00 [201] 42719-02 [201] 42791-02 [201] 42716-00 [202]  
42702-11 [200] 42719-00 [201] 42722-00 [201]

Cholecystectomy

30443-00 [965] 30454-01 [965] 30455-00 [965] 30445-00 [965] 30446-00 [965]  
30448-00 [965] 30449-00 [965]

**Comments (continued):** Coronary Artery Bypass Graft

38497-00 [672] 38497-01 [672] 39497-02 [672] 38497-03 [672] 38497-04 [673]  
38497-05 [673] 38497-06 [673] 39497-07 [673] 38500-00 [674] 38503-00 [674]  
38500-01 [675] 38503-01 [675] 38500-02 [676] 38503-02 [676] 38500-03 [677]  
38503-03 [677] 38500-04 [678] 38503-04 [678] 90201-00 [679] 90201-01 [679]  
90201-02 [679] 90201-03 [679]

Cystoscopy

36812-00 [1088] 36812-01 [1088] 36836-00 [1097]

Haemorrhoidectomy

32138-00 [949] 32132-00 [949] 32135-00 [949] 32135-01 [949]

Hysterectomy

35653-00 [1268] 35653-01 [1268] 35653-02 [1268] 35653-03 [1268] 35661-00 [1268]  
35670-00 [1268] 35667-00 [1268] 35664-00 [1268] 35657-00 [1269] 35750-00 [1269]  
35756-00 [1269] 35673-00 [1269] 35673-01 [1269] 35753-00 [1269] 35753-01 [1269]  
35756-01 [1269] 35756-02 [1269] 35667-01 [1269] 35664-01 [1269] 90450-00 [989]  
90450-01 [989] 90450-02 [989]

Inguinal herniorrhaphy

30614-03 [990] 30615-00 [997] 30609-03 [990] 30614-02 [990] 30609-02 [990]

Myringoplasty

41527-00 [313] 41530-00 [313] 41533-01 [313] 41542-00 [315] 41635-10 [313]

Myringotomy

41626-00 [309] 31626-01 [309] 41632-00 [309] 41632-01 [309]

Prostatectomy

37203-00 [1165] 37203-01 [1165] 37203-02 [1165] 37207-00 [1166] 37207-01 [1166]  
37200-00 [1166] 37200-01 [1166] 37203-05 [1166] 37203-06 [1166] 37200-03 [1167]  
37200-04 [1167] 37209-00 [1167] 37200-05 [1167] 90407-00 [1168] 36839-03 [1162]  
36869-01 [1162]

Septoplasty

41672-02 [379] 41679-03 [379]

Tonsillectomy

41789-00 [412] 41789-01 [412]

Total hip replacement

49318-00 [1489] 49319-00 [1489] 49324-00 [1492] 49327-00 [1492] 49330-00 [1492]  
49333-00 [1492] 49345-00 [1492]

Total knee replacement

49518-00 [1518] 49519-00 [1518] 49521-00 [1519] 49521-01 [1519] 49521-02 [1519]  
49521-03 [1519] 49524-00 [1519] 49524-01 [1519] 49527-00 [1524] 49530-00 [1523]  
49530-01 [1523] 49533-00 [1523] 49554-00 [1523] 49534-00 [1519]

Varicose Veins Stripping and Ligation

32508-00 [727] 32508-01 [727] 32511-00 [727] 32504-01 [728] 32505-00 [728]  
32514-00 [737]

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## Individual/group session

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*Admin. status:* CURRENT 1/07/1989

### Identifying and definitional attributes

*Knowledgebase ID:* 000235 Version number: 1

*Data element type:* DATA ELEMENT

*Definition:* A group is defined as two or more patients receiving services at the same time from the same hospital staff. However, this excludes the situation where individuals all belong to the same family. In such cases the service is being provided to the family unit and as a result the session should be counted as a single occasion of service to an individual.

*Context:* Required to distinguish between those occasions of service on an individual patient basis and those servicing groups of patients. This distinction has resource implications.

### Relational and representational attributes

*Datatype:* Alphanumeric Field size: Min. 5 Max. 5 Layout: ANNN.N

*Data domain:* A12.1 Individual sessions  
A12.2 Group sessions

### Administrative attributes

#### *National minimum data sets:*

Public hospital establishments from 1/07/2000 to

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## Main treatment type for alcohol and other drugs

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*Admin. status:* CURRENT 1/07/2001

### Identifying and definitional attributes

*Knowledgebase ID:* 000639 Version number: 1

*Data element type:* DATA ELEMENT

*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.

*Context:* Alcohol and other drug treatment services: Information about treatment provided is of fundamental importance to service delivery and planning.

### Relational and representational attributes

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

*Data domain:*

- 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

*Guide for use:* 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.

Code 1 refers to any form of withdrawal management, including medicated and non-medicated, in any delivery setting.

Code 2 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 refers to an intensive treatment program that integrates a range of services and therapeutic activities that may include 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.

Code 4 refers to pharmacotherapies that include those used as maintenance therapies (e.g. naltrexone, buprenorphine, LAAM and specialist methadone treatment). Use code 1 (withdrawal management) where a pharmacotherapy is used solely for withdrawal.

**Guide for use  
(continued):**

Code 5 refers to support and case management offered to clients (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 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 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.

**Collection methods:** Only one code to be selected.

**Related data:** Related to Other treatment type for alcohol and other drugs, version 1

**Administrative attributes**

**Source organisation:** Intergovernmental Committee on Drugs NMDS-WG

**National minimum data sets:**

Alcohol and other drug treatment services from 1/07/2001

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## Minutes of operating theatre time

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*Admin. status:* CURRENT 1/07/1989

### Identifying and definitional attributes

*Knowledgebase ID:* 000094 Version number: 1

*Data element type:* DATA ELEMENT

*Definition:* Total time spent by a patient in operating theatres during current episode of hospitalisation.

*Context:* Admitted patient care:

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 4 Max. 4 Layout: HHMM

*Data domain:* Time in hours and minutes

*Verification rules:* Right justified, zero filled.

### Administrative attributes

*Source organisation:* National Health Data Committee

*Comments:* This 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 data element has not been accepted for inclusion in the National minimum data set—admitted patient care.

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## Newborn qualification status

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*Admin. status:* CURRENT 1/07/2000

### Identifying and definitional attributes

*Knowledgebase ID:* 000343 Version number: 2

*Data element type:* DATA ELEMENT CONCEPT

*Definition:* Qualification status indicates whether the patient day within a newborn episode of care is either qualified or unqualified.

*Context:* Admitted patient care: To provide accurate information on care provided in newborn episodes of care through exclusion of unqualified patient days.

### Relational and representational attributes

*Guide for use:* A newborn qualification status is assigned to each patient day within a newborn episode of care.  
A newborn patient day is qualified if the infant meets at least one of the following criteria:

- is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient;
- is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the purpose of the provision of special care;
- is admitted to, or remains in hospital without its mother.

A newborn patient day is unqualified if the infant does not meet any of the above criteria.

The day on which a change in qualification status occurs is counted as a day of the new qualification status.

If there is more than one qualification status in a single day, the day is counted as a day of the final qualification status for that day.

*Related data:* supersedes previous data element Qualification status, version 1  
used in conjunction with Admitted patient, version 3  
used in conjunction with Care type, version 4  
is used in the calculation of Date of change to qualification status, version 1  
is used in the calculation of Number of qualified days for newborns, version 2

### Administrative attributes

*Comments:* All babies born in hospital are admitted patients.  
The newborn baby's qualified days are eligible for health insurance benefits purposes and the patient day count under the Australian Health Care Agreements. In this context, newborn qualified days are equivalent to acute days and may be denoted as such.  
The days when a newborn baby does not meet these criteria are classified as unqualified (if they are nine days old or less) and should not be counted as patient days under the Australian Health Care Agreements and are not eligible for health insurance benefit purposes.

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## Non-admitted patient service event

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*Admin. status:* CURRENT 1/07/2000

### Identifying and definitional attributes

*Knowledgebase ID:* 000438 Version number: 1

*Data element type:* DATA ELEMENT CONCEPT

*Definition:* An interaction between one or more health care professionals with one or more non-admitted patients, for assessment, consultation and/or treatment intended to be unbroken in time. A service event means that a dated entry is made in the patient/client's medical record.

*Context:* Hospital non-admitted patient care: This definition applies to non-admitted hospital patients and is not intended to apply to community based services.

### Relational and representational attributes

*Guide for use:* The period of interaction can be broken but still regarded as one service event if it was intended to be unbroken in time. This covers those circumstances in which treatment during a service event is temporarily interrupted for unexpected reasons, for example, a clinician is called to assess another patient who requires more urgent care.

Service events can occur in an outpatient, emergency, radiology, pathology and/or pharmacy department or, by a hospital-based outreach service, in a location that is not part of the hospital campus.

Service events may or may not be pre-arranged (except for telephone calls).

Imaging, pathology and/or pharmacy services that are ASSOCIATED with a service event in an outpatient clinic, Emergency Department or outreach service are NOT regarded as service events themselves.

Imaging, pathology or pharmacy services provided INDEPENDENT of a service event in an outpatient clinic, Emergency Department or outreach service are regarded as individual service events.

Service events delivered via a telephone call are included if

- they are a substitute for a face-to-face service event, and
- they are pre-arranged, and
- a record of the service event is included in the patient's medical record.

Service events include when the patient is participating via a video link (telemedicine). A service event can be counted at each site participating via the video link.

If a carer/relative accompanies a patient during a service event, this is not considered to be a service event for the carer/relative, 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.

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.

**Guide for use  
(continued):**

A service event is regarded as having occurred for each patient who attends a group session such as an antenatal class.

Outpatient department services provided to admitted patients are not regarded as service events.

Work-related services provided in clinics for staff are not service events.

Definitions:

An Emergency Department provides triage, assessment, care and/or treatment for patients suffering from medical condition/s and/or injury.

Hospital based outreach services events relate to treatment of patients by hospital staff in a location that is not part of the hospital campus (such as in the patient's home or place of work).

**Related data:**

used in conjunction with Non-admitted patient service event count, version 1

used in conjunction with Multi-disciplinary team status, version 1

used in conjunction with Non-admitted patient service type, version 1

used in conjunction with Non-admitted patient service mode, version 1

used in conjunction with Non-admitted patient service event – patient present status, version 1

used in conjunction with Individual/group session, version 1

**Administrative attributes**

**Source organisation:** National Health Data Committee

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## Non-admitted patient service mode

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*Admin. status:* CURRENT 1/07/2000

### Identifying and definitional attributes

*Knowledgebase ID:* 000439 Version number: 1

*Data element type:* DATA ELEMENT

*Definition:* Relative physical location of the patient, provider and the hospital campus of the provider of a non-admitted patient service event.

*Context:* Hospital non-admitted patient care:

### Relational and representational attributes

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

*Data domain:*

- 1 Patient and provider in the same physical location
  - 1.1 On the hospital campus of the provider
  - 1.2 Not on the hospital campus of the provider
- 2 Patient and provider not in the same physical location, and communicating via:
  - 2.1 Telephone
  - 2.2 Telemedicine

*Guide for use:* Patient and provider in the same physical location refers to face to face contacts. If this occurs at the hospital campus of the provider, use code 1.1. If the service event does not occur on the hospital campus of the provider (hospital-based outreach services), use code 1.2. Hospital-based outreach service events occur when the patient is treated by hospital staff in a location that is not part of the hospital campus (such as in the patient's home or place of work).

Patient and provider not in the same physical location refers to service events delivered via a telephone call or video link (telemedicine). The provider may or may not be physically present on their hospital campus.

A service event delivered via a telephone call is included if

- it is a substitute for a face-to-face service event, and
- it is pre-arranged, and
- a record of the service event is included in the patient's medical record.

A service event can be counted at each site participating via a video link.

*Related data:* used in conjunction with Non-admitted patient service event count, version 1  
used in conjunction with Non-admitted patient service event, version 1  
used in conjunction with Non-admitted patient service type, version 1  
used in conjunction with Multi-disciplinary team status, version 1  
used in conjunction with Individual/group session, version 1

### Administrative attributes

*Source organisation:* National Health Data Committee

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## Non-admitted patient service type

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*Admin. status:* CURRENT 1/07/2000

### Identifying and definitional attributes

*Knowledgebase ID:* 000440 Version number: 1

*Data element type:* DATA ELEMENT

*Definition:* The type of clinical service provided to a non-admitted patient in a non-admitted patient service event.

*Context:* Hospital non-admitted patient care: This definition applies to non-admitted hospital patients and is not intended to apply to community based services.

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 1 Max. 5 Layout: NN.NN

*Data domain:*

1	Allied health and/or clinical nurse specialist
2	Dental
3	Imaging
4	Medical
5	Obstetrics and gynaecology
6	Paediatrics
7	Pathology
8	Pharmacy
9	Psychiatric
10	Surgical
11	Emergency department

*Guide for use:* The following provides a guide to types of clinical services that are included in each of the categories in the data domain. Clinical services that are not specifically identified in this Guide for use should be classified as one of the groups in the data domain on the basis of the type of clinical professional staff involved in providing the service event.

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

#### Clinical service type

Allied Health and/or  
clinical nurse specialist

#### Clinical service examples

Audiology  
Clinical pharmacy  
Diabetes education  
Neuropsychology  
Nutrition/dietetics  
Occupational therapy  
Optometry  
Orthoptics  
Orthotics  
Physiotherapy  
Podiatry  
Prosthetics  
Psychology

**Guide for use  
(continued):**

	Social work
	Speech pathology
	Stomal therapy
	Wound management
Dental . . . . .	Dental
Imaging . . . . .	Medical imaging
Medical . . . . .	Aged Care
	Alcohol and other drug
	Allergy
	Anti-coagulant
	Asthma
	Cardiology
	Clinical measurement
	Dermatology
	Dementia
	Developmental disabilities
	Diabetes
	Endocrine
	Epilepsy
	Falls
	Gastroenterology
	General internal medicine
	Genetic
	Haematology
	Hepatobiliary
	Hypertension
	Hyperbaric medicine
	Immunology
	Infectious diseases
	Medical oncology
	Metabolic bone
	Nephrology
	Neurology
	Occupational medicine
	Palliative care
	Pain management
	Pulmonary
	Radiation oncology
	Rehabilitation
	Respiratory
	Rheumatology
	Spinal
	Transplants
Obstetrics and gynaecology . . . . .	Family planning
	Gynaecology
	Gynaecology oncology
	Obstetrics
	Assisted Reproductive Technology
Pathology . . . . .	Pathology
Paediatrics . . . . .	Adolescent health
	Neonatal
	Paediatric medicine
	Paediatric surgery
Pharmacy . . . . .	Dispensing pharmacy
Psychiatric . . . . .	Psychiatry

**Guide for use  
(continued):**

Surgical ..... Breast  
 Burns  
 Cardiac surgery  
 Colorectal  
 Craniofacial  
 Ear, nose and throat  
 Fracture  
 General surgery  
 Neurosurgery  
 Ophthalmology  
 Orthopaedics  
 Plastic surgery  
 Pre-admission  
 Pre-anaesthesia  
 Thoracic surgery  
 Urology  
 Vascular surgery

Emergency department ..... Emergency department  
 An Emergency Department provides triage, assessment, care and/or treatment for patients suffering from medical condition/s and/or injury.

**Related data:**

used in conjunction with Non-admitted patient service event count, version 1  
 used in conjunction with Non-admitted patient service event, version 1  
 used in conjunction with Multi-disciplinary team status, version 1  
 (used in conjunction with New/repeat status, version 1, if required)  
 used in conjunction with Individual/group session, version 1

**Administrative attributes**

**Source organisation:** National Health Data Committee

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## Non-elective care

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*Admin. status:* CURRENT 1/07/1996

### Identifying and definitional attributes

*Knowledgebase ID:* 000105 Version number: 1

*Data element type:* DATA ELEMENT CONCEPT

*Definition:* Care that, in the opinion of the treating clinician, is necessary and admission for which cannot be delayed for more than 24 hours.

*Context:* Admitted patient care:

### Administrative attributes

*Source organisation:* Hospital Access Program Waiting Lists Working Group/National Health Data Committee

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## Number of contacts (psychiatric outpatient clinic/day program)

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*Admin. status:* CURRENT 1/07/1989

### Identifying and definitional attributes

*Knowledgebase ID:* 000141 Version number: 1

*Data element type:* DATA ELEMENT

*Definition:* Number of days that a patient attended a psychiatric outpatient clinic or a day program during the relevant financial year.

*Context:* Mental health statistics: this data element gives a measure of the level of service provided.

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 1 Max. 3 Layout: NNN

*Data domain:* Count in number of days

*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.)

*Related data:* is an alternative to Number of service contact dates, version 2

### Administrative attributes

*Source organisation:* National minimum data set working parties

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## Number of days in special/neonatal intensive care

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*Admin. status:* CURRENT 1/07/1997

### Identifying and definitional attributes

*Knowledgebase ID:* 000009 Version number: 2

*Data element type:* DATA ELEMENT

*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: 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.

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 1 Max. 3 Layout: NNN

*Data domain:* Number, representing the number of days spent in the special/intensive care nursery.

*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.

Special care nurseries (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 NICNs also provide consultative services to other hospitals.

*Related data:* supersedes previous data element Admission to special/neonatal intensive care, version 1

### Administrative attributes

*Source organisation:* National Perinatal Data Development Committee

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## Number of service contact dates

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*Admin. status:* CURRENT 1/07/1999

### Identifying and definitional attributes

*Knowledgebase ID:* 000141 Version number: 2

*Data element type:* DERIVED DATA ELEMENT

*Definition:* The number of dates where a service contact was recorded for the patient/client.

*Context:* Community-based mental health care: This data element gives a measure of the level of service provided to a patient/client.

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 1 Max. 3 Layout: NNN

*Data domain:* Count of dates

*Guide for use:* This data element 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.

*Collection methods:* For collection from community based (ambulatory and non-residential) agencies. Includes mental health day programs and psychiatric outpatients.

*Related data:* is an alternative to Number of contact (psychiatric outpatient clinic/day program), version 1

relates to concept Service contact, version 1

is derived from Service contact date, version 1

### Administrative attributes

*Source organisation:* National Mental Health Information Strategy Committee

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## Nursing interventions

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*Admin. status:* CURRENT 1/07/1998

### Identifying and definitional attributes

*Knowledgebase ID:* 000112 Version number: 2

*Data element type:* DATA ELEMENT

*Definition:* The nursing action/s intended to relieve or alter a person's responses to actual or potential health problems.

*Context:* 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.

### Relational and representational attributes

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

*Data domain:*

- 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

*Guide for use:* 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 following definitions are to assist in coding:

- 1 COORDINATION AND COLLABORATION OF CARE  
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).
- 2 SUPPORTING INFORMATION CARERS  
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.

**Guide for use  
(continued):**

- 3 GENERAL NURSING CARE  
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.
- 4 TECHNICAL NURSING TREATMENT OR PROCEDURE  
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.
- 5 COUNSELLING AND EMOTIONAL SUPPORT  
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.
- 6 TEACHING/EDUCATION  
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.
- 7 MONITORING AND SURVEILLANCE  
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.
- 8 FORMAL CASE MANAGEMENT  
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.
- 9 SERVICE NEEDS ASSESSMENT ONLY  
is 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.

**Verification rules:**

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 7 in Goal of care 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 CNMDSA interventions enabling the option of a rich level of detail of activities or summarised information.

**Related data:** relates to Nursing goal, version 1  
supersedes previous data element Nursing interventions, version 1  
relates to Nursing diagnosis, version 2

### **Administrative attributes**

**Source organisation:** Australian Council of Community Nursing Services

**Comments:** 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 Nursing interventions or other more relevant code sets.

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## Organ procurement—posthumous

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*Admin. status:* CURRENT 1/07/2000

### Identifying and definitional attributes

*Knowledgebase ID:* 000441 Version number: 1

*Data element type:* DATA ELEMENT CONCEPT

*Definition:* Organ procurement – posthumous is an activity undertaken by hospitals in which human tissue is procured for the purpose of transplantation from a donor who has been declared brain dead.

*Context:* Hospital activity:

### Relational and representational attributes

*Guide for use:* This activity is not regarded as care or treatment of an admitted patient, but is registered by the hospital. Diagnoses and procedures undertaken during this activity, including mechanical ventilation and tissue procurement, are recorded in accordance with the Australian Coding Standards.

Declarations of brain death are made in accordance with relevant State/Territory legislation.

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## Procedure

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*Admin. status:* CURRENT 1/07/1999

### Identifying and definitional attributes

*Knowledgebase ID:* 000137 Version number: 5

*Data element type:* DATA ELEMENT

*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 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.

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 7 Max. 7 Layout: NNNNN-NN

*Data domain:* Valid ICD-10 code

*Guide for use:* Admitted patients: record all procedures undertaken during an episode of care in accordance with the ICD-10-AM (2nd 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; or
- diagnostic/exploratory procedure related to an additional diagnosis for the episode of care.

The first edition of ICD-10-AM, the Australian modification of ICD-10, was published by the National Centre for Classification in Health and implemented from July 1998. The 2nd edition was published for use from July 2000.

*Verification rules:* As a minimum requirement procedure codes must be valid codes from ICD-10-AM 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. Record and code all procedures undertaken during the episode of care in accordance with the ICD-10-AM (2nd edition) Australian Coding.

*Collection methods:* Standards. 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. Procedures are derived from and must be substantiated by clinical documentation.

**Related data:** supersedes previous Principal procedure – ICD-9-CM code, version 3  
supersedes previous Additional procedures – ICD-9-CM code, version 3  
used in conjunction with Indicator procedure, version 3  
is qualified by Principal diagnosis, version 3  
is qualified by Additional diagnosis, version 4  
supersedes previous Principal procedure – ICD-10-AM code, version 4  
supersedes previous Additional procedures – ICD-10-AM code, version 4

### **Administrative attributes**

**Source document:** International Statistical Classification of Diseases and Related Health Problems – Tenth Revision – Australian Modification (2nd edition); National Centre for Classification in Health, Sydney.

**Source organisation:** National Centre for Classification in Health, National Health Data Committee

**National minimum data sets:**

Admitted patient care from 1/07/1999 to

**Comments:** The National Centre for Classification in Health advises the National Health Data Committee of relevant changes to the ICD-10-AM.

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## Service contact

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*Admin. status:* CURRENT 1/07/1999

### Identifying and definitional attributes

*Knowledgebase ID:* 000401 Version number: 1

*Data element type:* DATA ELEMENT CONCEPT

*Definition:* A contact between a patient/client and an ambulatory care health unit (including outpatient and community health units) which results in a dated entry being made in the patient/client record.

*Context:* Identifies service delivery at the patient level for mental health services (including consultation/liaison, mobile and outreach services).

A service contact can include either face-to-face, telephone or video link service delivery modes. Service contacts would either be with a client, carer or family member or another professional or mental health worker involved in providing care and do not include contacts of an administrative nature (e.g. telephone contact to schedule an appointment) except where a matter would need to be noted on a patient's record.

Service contacts may be differentiated from administrative and other types of contacts by the need to record data in the client record. However, there may be instances where notes are made in the client record that have not been prompted by a service contact with a patient/client (e.g. noting receipt of test results that require no further action). These instances would not be regarded as a service contact.

### Relational and representational attributes

*Related data:* relates to Number of service contact dates, version 2  
relates to Number of service contacts within a treatment episode for alcohol and other drugs, version 1  
relates to Service contact date, version 1

### Administrative attributes

*Comments:* The proposed definition is not able to measure case complexity or level of resource usage with each service contact alone. This limitation also applies to the concept of occasions of service (in admitted patient care) and hospital separations. Some overlap with the data element Occasions of service is acknowledged by the National Health Data Committee.

The National Health Data Committee also 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 currently covered by this data element concept.

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## Service contact date

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*Admin. status:* CURRENT 1/07/1999

### Identifying and definitional attributes

*Knowledgebase ID:* 000402 Version number: 1

*Data element type:* DATA ELEMENT

*Definition:* The date of each service contact between a health service provider and patient/client.

*Context:* Community-based mental health care: 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.

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

*Data domain:* Valid date

*Guide for use:* 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.

*Collection methods:* For collection from community based (ambulatory and non-residential) agencies.

*Related data:* is used in the derivation of Number of service contact dates, version 2  
relates to concept Service contact, version 1

### Administrative attributes

#### *National minimum data sets:*

Community mental health care from 1/07/2000 to

*Comments:* 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 via this data element.

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## Time of commencement of service event

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*Admin. status:* CURRENT 1/07/2001

### Identifying and definitional attributes

*Knowledgebase ID:* 000357 Version number: 2

*Data element type:* DATA ELEMENT

*Definition:* The time at which the delivery of a service commences. The service is defined as commencing when a health care professional first takes responsibility for the patient/client's care.

*Context:* Community health care:  
Hospital non-admitted patient care:

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 4 Max. 4 Layout: HHMM

*Data domain:* Expressed as hours and minutes using 24-hour clock

*Related data:* supersedes Time of service event, version 1  
relates to Emergency Department waiting time to service delivery, version 1  
relates to Emergency Department waiting time to admission, version 1  
relates to concept Patient presentation at Emergency Department, version 1  
relates to Date of commencement of service event, version 2  
relates to Date patient presents, version 2  
relates to Time patient presents, version 2  
relates to Date of triage, version 1  
relates to Time of triage, version 1

### Administrative attributes

*Source organisation:* National Institution Based Ambulatory Model Reference Group; NHDC

*National minimum data sets:*

Emergency Department waiting times from 1/07/1999 to

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## Treatment episode for alcohol and other drugs

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*Admin. status:* CURRENT 1/07/2001

### Identifying and definitional attributes

*Knowledgebase ID:* 000647 Version number: 1

*Data element type:* DATA ELEMENT CONCEPT

*Definition:* The period of contact, with defined dates of commencement and cessation, between a client and a treatment provider or team of providers that occurs in one setting and in which there is no change in the main treatment type or principal drug of concern, and there has not been a non-planned absence of contact for greater than 3 months.

*Context:* Alcohol and drug treatment services: This concept is required to provide the basis for a standard approach to recording and monitoring patterns of service utilisation by clients.

### Relational and representational attributes

*Guide for use:* A treatment episode can have only one 'main treatment type for alcohol and other drugs' and only one 'principal drug of concern'.

A treatment episode must have a defined 'date of commencement of treatment episode for alcohol and other drugs' and a 'date of cessation of treatment episode for alcohol and other drugs'.

A treatment episode is only delivered within one setting. Where an agency operates in more than one treatment delivery setting, for any client receiving treatment in multiple settings, a separate treatment episode is required for each setting. Consequently, more than one treatment episode may be in progress for a client at the same time, and it is possible for each of these episodes to have different dates of commencement and cessation.

*Collection methods:* Is taken as the period starting from the date of commencement of treatment and ending at the date of cessation of treatment episode.

*Related data:* Relates to Main treatment type for alcohol and other drugs, version 1  
 Relates to Treatment delivery setting for alcohol and other drugs, version 1  
 Relates to Date of commencement of treatment episode for alcohol and other drugs, version 2  
 Relates to Date of cessation of treatment episode for a alcohol and other drugs, version 2  
 Relates to the concept Commencement of treatment episode for alcohol and other drugs, version 2  
 Relates to the concept Cessation of treatment episode for alcohol and other drugs, version 2

### Administrative attributes

*Source organisation:* Intergovernmental Committee on Drugs NMDS-WG

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## Census date

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*Admin. status:* CURRENT 1/07/1997

### Identifying and definitional attributes

*Knowledgebase ID:* 000174 Version number: 2

*Data element type:* DATA ELEMENT

*Definition:* Date on which the hospital takes a point in time (census) count of and characterisation of patients on the waiting list.

*Context:* Elective surgery: this data element is necessary for the calculation of the waiting time until a census.

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

*Guide for use:* This date is recorded when a census is done of the patients on a waiting list.

*Related data:* supersedes previous data element Census date, version 1  
is used in the calculation of Waiting time at a census date, version 1

### Administrative attributes

*Source organisation:* National Health Data Committee

*National minimum data sets:*

Elective surgery waiting times from 1/07/1994 to

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## Hospital census

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*Admin. status:* CURRENT 1/01/1995

### Identifying and definitional attributes

*Knowledgebase ID:* 000066 Version number: 1

*Data element type:* DATA ELEMENT CONCEPT

*Definition:* A point in time count by a hospital of all its admitted patients and/or patients currently on a waiting list.

*Context:* Admitted patient care:

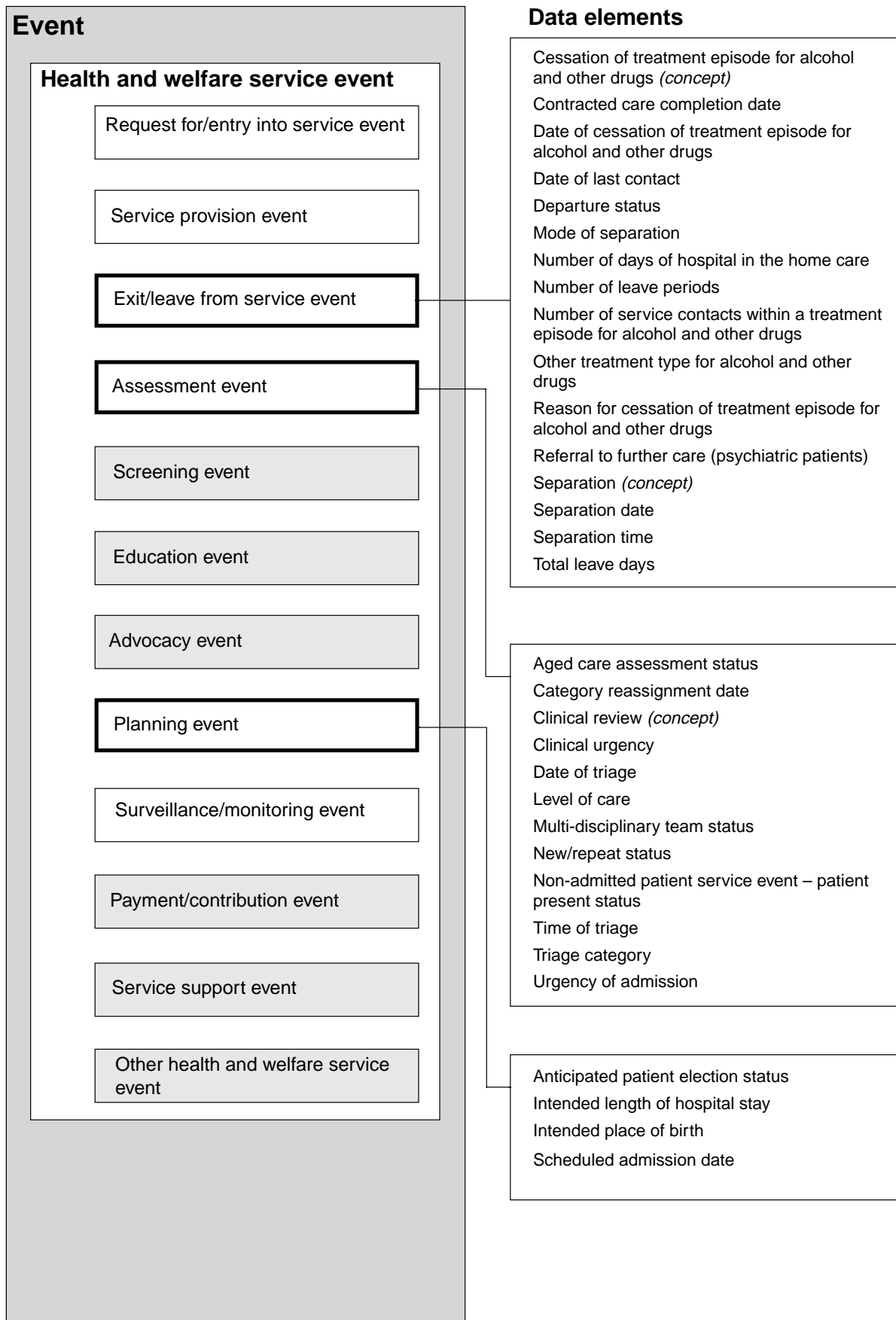
### Relational and representational attributes

*Related data:* relates to Census date, version 2

relates to Waiting time at a census date, version 1



# National Health Information Model entity



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## Cessation of treatment episode for alcohol and other drugs

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*Admin. status:* CURRENT 1/07/2001

### Identifying and definitional attributes

*Knowledgebase ID:* 000422 Version number: 2

*Data element type:* DATA ELEMENT CONCEPT

*Definition:* Cessation of a treatment episode occurs when treatment is completed or discontinued; or there has been a change in the principal drug of concern, the main treatment type, or the treatment delivery setting.

*Context:* Alcohol and other drug treatment services:

### Relational and representational attributes

*Guide for use:* A client is identified as ceasing a treatment episode if one or more of the following apply:

- their treatment plan is completed;
- they have had no contact with the treatment provider for a period of three months, nor is there a plan in place for further contact;
- their 'principal drug of concern for alcohol and other drugs' has changed;
- their 'main treatment type for alcohol and other drugs' has changed;
- their 'treatment delivery setting for alcohol and other drugs' has changed;
- their treatment has ceased for other reasons (e.g. imprisoned, ceased treatment against advice, transferred to another service provider, died etc)

*Related data:* supersedes previous concept Cessation of treatment, version 1

relates to Reason for cessation of treatment episode for alcohol and other drugs, version 2

relates to Date of cessation of treatment episode for alcohol and other drugs, version 2

### Administrative attributes

*Source organisation:* Intergovernmental Committee on Drugs NMDS-WG

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## Contracted care completion date

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*Admin. status:* CURRENT 1/07/2000

### Identifying and definitional attributes

*Knowledgebase ID:* 000428 Version number: 1

*Data element type:* DATA ELEMENT

*Definition:* The date the period of contracted care commenced.

*Context:* Admitted patient care:

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

*Data domain:* Valid dates

*Guide for use:* This item is to be used by the contracting hospital to record the commencement date of the contracted hospital care and will be the admission date for the contracted hospital.

*Related data:*

- relates to concept Contracted hospital care, version 1
- relates to Contract type, version 1
- relates to Contract role, version 1
- relates to Contract establishment identifier, version 3
- relates to Contracted care completion date, version 1
- relates to Total contract patient days, version 1
- relates to Contract procedure flag, version 1

### Administrative attributes

*Source organisation:* National Health Data Committee

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## Date of cessation of treatment episode for alcohol and other drugs

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*Admin. status:* CURRENT 1/07/2001

### Identifying and definitional attributes

*Knowledgebase ID:* 000424 Version number: 2

*Data element type:* DATA ELEMENT

*Definition:* Date on which a treatment episode for alcohol and other drugs ceases.

*Context:* Alcohol and other drug treatment services: Required to identify the cessation of a treatment episode by an alcohol and other drug treatment service.

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

*Data domain:* Valid dates

*Guide for use:* Refers to the date of the last service contact in a treatment episode between the client and staff of the treatment provider. In situations where the client has had no contact with the treatment provider for three months, nor is there a plan in place for further contact, the date of last service contact should be used.

Refer to data element concept 'Cessation of treatment episode for alcohol and other drugs' to determine when a treatment episode ceases.

*Verification rules:* Must be later than or the same as the 'Date of commencement of treatment for alcohol and other drugs'.

*Related data:* supersedes previous data element Date of cessation of treatment, version 1  
relates to Reason for cessation of treatment episode for alcohol and other drugs, version 2  
relates to the concept Cessation of treatment episode for alcohol and other drugs, version 2

### Administrative attributes

*Source organisation:* Intergovernmental Committee on Drugs NMDS-WG

*National minimum data sets:*

Alcohol and other drug treatment services from 01/07/2000

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## Date of last contact

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*Admin. status:* CURRENT 1/07/1998

### Identifying and definitional attributes

*Knowledgebase ID:* 000040 Version number: 2

*Data element type:* DATA ELEMENT

*Definition:* Date of the last contact between a staff member of the community service and a person in any setting.

The definition includes:

- visits made to persons in institutional settings for the purpose of handing over or otherwise completing a care episode;
- bereavement visits in any setting;
- visits made to the person's home to complete the service, including the collection of equipment.

The definition excludes visits made by liaison/discharge planning staff of a community service for the purpose of assessment of need related to a subsequent episode of care.

*Context:* To enable analysis of time periods throughout a care episode, especially the bereavement period. This date has been included in order to capture the end of a care episode in terms of involvement of the community nursing service.

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

*Data domain:* Valid dates

*Guide for use:* This could be the same as the date of discharge.

*Verification rules:* May occur after or on the same day as Date of last delivery of service

*Related data:* supersedes Date of last community service contact with client/family, version 1  
relates to Date of first contact, version 2

### Administrative attributes

*Source organisation:* Australian Council of Community Nursing Services

*Comments:* Although the data item has Recommended status only, if service agencies are committed to monitoring all resource utilisation associated with an episode of care, this post-discharge date and the corresponding pre-admission item Date of first contact, have a place within an agency information system. This is particularly true for those agencies providing discharge planning service or specialist consultancy or assessment services.

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## Departure status

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*Admin. status:* CURRENT 1/07/1998

### Identifying and definitional attributes

*Knowledgebase ID:* 000359 Version number: 1

*Data element type:* DATA ELEMENT

*Definition:* The status of the patient on departure from the Emergency Department.

*Context:* Admitted patient care: Required for analysis of client care.

### Relational and representational attributes

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

*Data domain:*

- 1 Admitted to ward or other admitted patient unit (includes patients who may have been in observation area in Emergency Department prior to admission).
- 2 Emergency department service event completed, departed under own care.
- 3 Transferred to another hospital for admission.
- 4 Did not wait to be attended (by medical officer).
- 5 Left at own risk, after medical officer assumed responsibility for the patient but before Emergency Department service event was completed.
- 6 Died in Emergency Department.
- 7 Dead on arrival, not treated in Emergency Department.

*Related data:*

- relates to Admission date, version 3
- relates to Emergency Department waiting time to service delivery, version 1
- relates to Emergency Department waiting time to admission, version 1
- relates to concept Patient presentation at Emergency Department, version 1
- relates to Date patient presents, version 2
- relates to Time patient presents, version 2
- relates to Type of visit to Emergency Department, version 2
- relates to Date of triage, version 1
- relates to Time of triage, version 1
- relates to Triage category, version 1
- relates to Date of commencement of service event, version 2
- relates to Time of commencement of service event, version 2
- relates to Admission time, version 1

### Administrative attributes

*Source organisation:* National Institution Based Ambulatory Model Reference Group; NHDC

*National minimum data sets:*

Emergency Department waiting times from 1/07/1999 to

*Comments:* This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department Waiting Times National Minimum Data Set.

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## Mode of separation

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*Admin. status:* CURRENT 1/07/2000

### Identifying and definitional attributes

*Knowledgebase ID:* 000096 Version number: 3

*Data element type:* DATA ELEMENT

*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.

### Relational and representational attributes

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

*Data domain:*

- 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))

*Guide for use:* For Code 4 – 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.

*Related data:* is supplemented by Source of referral to public psychiatric hospital, version 3  
 is supplemented by Source of referral to acute hospital or private psychiatric hospital, version 3  
 supersedes Mode of separation, version 2  
 is used in the derivation of Diagnosis related group, version 1

## Administrative attributes

**Source organisation:** National Health Data Committee

**National minimum data sets:**

Admitted patient care from 1/07/2000 to

Admitted patient mental health care from 1/07/2000 to

Admitted patient palliative care from 1/07/2000 to

**Comments:** During 2000, the National Mental Health Information Strategy Committee is reviewing a draft data element 'Referral to further care' which will involve a review of the data element Mode of separation.

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## Number of days of hospital in the home care

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*Admin. status:* CURRENT 1/07/2001

### Identifying and definitional attributes

*Knowledgebase ID:* 000640 Version number: 1

*Data element type:* DERIVED DATA ELEMENT

*Definition:* The number of hospital in the home days occurring within an episode of care for an admitted patient.

*Context:* Admitted patient care:

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 0 Max. 3 Layout: NNN

*Data domain:* Integer count of number of days

*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.

*Related data:* relates to the concept Hospital in the home care, version 1

relates to the concept Admitted patient, version 3

relates to the concept Episode of care, version 1

relates to Admission date, version 4

relates to Separation date, version 5

### Administrative attributes

*Source organisation:* National Health Data Committee

#### *National minimum data sets:*

Admitted patient care from 1/07/2001 to

Admitted patient mental health care from 1/07/2001 to

Admitted patient palliative care from 1/07/2001 to

*Comments:* 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.

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## Number of leave periods

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*Admin. status:* CURRENT 1/07/1996

### Identifying and definitional attributes

*Knowledgebase ID:* 000107 Version number: 3

*Data element type:* DATA ELEMENT

*Definition:* Number of leave periods 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.

*Context:* 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.

### Relational and representational attributes

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

*Data domain:* Number of leave periods

*Guide for use:* If the period of leave is greater than seven days or of the patient fails to return from leave, the patient is discharged.

*Related data:* is used in the derivation of Length of stay, version 3  
supersedes Number of leave periods, version 2

### Administrative attributes

*Source organisation:* National Health Data Committee

#### *National minimum data sets:*

Admitted patient care from 1/07/2000 to

*Comments:* 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.

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

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*Admin. status:* CURRENT 1/07/2001

### Identifying and definitional attributes

*Knowledgebase ID:* 000641 Version number: 1

*Data element type:* DATA ELEMENT

*Definition:* Number of service contacts made with a client for the purpose of providing alcohol and other drug treatment during a treatment episode.

*Context:* Alcohol and drug treatment services: This data element provides a measure of the frequency of client contact and service utilisation within a treatment episode.

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 1 Max. 3 Layout: NNN

*Data domain:* Valid integer

*Guide for use:* This data element is a count of therapeutic contacts 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 data element is not collected for residential clients.

Where multiple service provider staff have contact with the client on the same occasion of service, the contact is counted only once. Where the client has multiple contacts on a single day, contact is counted only once.

*Collection methods:* To be collated at the close of an episode. The total number of contacts are calculated or counted for the closed episode.

*Related data:* Relates to the concept Service contact, version 1

Relates to the concept Treatment episode for alcohol and other drugs, version 1.

### Administrative attributes

*Source organisation:* Intergovernmental Committee on Drugs NMDS-WG

#### *National minimum data sets:*

Alcohol and other drug treatment services from 01/07/2001

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## Other treatment type for alcohol and other drugs

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**Admin. status:** CURRENT 1/07/2001

### Identifying and definitional attributes

**Knowledgebase ID:** 000642 Version number: 1

**Data element type:** DATA ELEMENT

**Definition:** All other forms of treatment provided to the client in addition to the 'main treatment type for alcohol and other drugs'.

**Context:** Alcohol and other drug treatment services: Information about treatment provided is of fundamental importance to service delivery and planning.

### Relational and representational attributes

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

**Data domain:**

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

**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 a 'other drug of concern'.

Code 1 refers to any form of withdrawal management, including medicated and non-medicated.

Code 2 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 refers to an intensive treatment program that integrates a range of services and therapeutic activities that may include 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.

Code 4 refers to pharmacotherapies that include those used as maintenance therapies (e.g. naltrexone, buprenorphine, LAAM and specialist methadone treatment). Use code 1 (withdrawal management) where a pharmacotherapy is used solely for withdrawal.

**Collection methods:** More than one code may be selected. This field should be left blank if there are no other treatment types for the episode.

**Related data:** Related to Main treatment type for alcohol and other drugs, version 1

**Administrative attributes**

*Source organisation:* Intergovernmental Committee on Drugs NMDS-WG

*National minimum data sets:*

Alcohol and other drug treatment services from 1/07/2001

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## Reason for cessation of treatment episode for alcohol and other drugs

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*Admin. status:* CURRENT 1/07/2001

### Identifying and definitional attributes

*Knowledgebase ID:* 000423 Version number: 2

*Data element type:* DATA ELEMENT

*Definition:* The reason for the client ceasing to receive a treatment episode from an alcohol and other drug treatment service.

*Context:* Alcohol and other drug treatment services: Given the levels of attrition within alcohol and other drug treatment programs, it is important to identify the range of different reasons for ceasing treatment with a service.

### Relational and representational attributes

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

*Data domain:*

- 1 Treatment completed
- 2 Change in main treatment type
- 3 Change in the delivery setting
- 4 Change in the principal drug of concern
- 5 Transferred to another service provider
- 6 Ceased to participate against advice
- 7 Ceased to participate without notice
- 8 Ceased to participate involuntary (non-compliance)
- 9 Ceased to participate at expiation
- 10 Ceased to participate by mutual agreement
- 11 Drug court and/or sanctioned by court diversion service
- 12 Imprisoned, other than drug court sanctioned
- 13 Died
- 98 Other
- 99 Not stated/inadequately described

*Guide for use:*

Code 1 is to be used when all of the immediate goals of the treatment plan have been fulfilled

Code 2 a treatment episode will end if there is a change in the 'Main treatment type for alcohol and other drugs'

Code 3 a treatment episode will end if there is a change in the 'Treatment delivery setting for alcohol and other drugs'

Code 4 a treatment episode will end if there is a change in the 'Principal drug of concern'.

Code 5 includes situations where the service provider is no longer the most appropriate and the client is transferred/referred to another service. For example, transfers could occur for clients between non-residential and residential services or between residential services and a hospital.

**Guide for use  
(continued):**

- Code 6 refers to situations where the service provider is aware of the client's intention to stop participating in treatment, and the client ceases despite advice from staff that such action is against the client's best interest.
- Code 7 refers to situations where the client ceased to receive treatment without notifying the service provider of their intention to no longer participate.
- Code 8 refers to situations where the client's participation has been ceased by the service provider due to non-compliance with the rules or conditions of the program.
- Code 9 refers to situations where the client has fulfilled their obligation to satisfy expiation requirements (e.g. participate in a treatment program to avoid having a criminal conviction being recorded against them) as part of a police or court diversion scheme and chooses not to continue with the treatment program.
- Code 10 refers to situations where the client ceases participation by mutual agreement with the service provider even though the treatment plan has not been completed. This may include situations where the client has moved out of the area. To be used when codes 2, 3 or 4 is not applicable.
- Code 11 applies to drug court and/or court diversion service clients who are sanctioned back into jail for non-compliance with the program.
- Code 12 applies to clients who are imprisoned for reasons other than code 11.

**Collection methods:**

To be collected on cessation of a treatment episode.

**Related data:**

supersedes previous Reason for cessation of treatment, version 1

relates to the concept Cessation of treatment episode for alcohol and other drugs, version 2

relates to Date of cessation of treatment episode for alcohol and other drugs, version 2

**Administrative attributes**

**Source organisation:** Intergovernmental Committee on Drugs NMDS-WG

**National minimum data sets:**

Alcohol and other drug treatment services

from 01/07/2000

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## Referral to further care (psychiatric patients)

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*Admin. status:* CURRENT 1/07/1989

### Identifying and definitional attributes

*Knowledgebase ID:* 000143 Version number: 1

*Data element type:* DATA ELEMENT

*Definition:* Referral to further care by health service agencies/facilities.

*Context:* Mental health care: many psychiatric inpatients have continuing needs for post-discharge care. Continuity of care across the hospital-community interface is a key policy theme emerging in the various States and Territories. Inclusion of this item allows the opportunity to monitor interagency linkages and is complementary to the data element Source of referral.

### Relational and representational attributes

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

*Data domain:*

- 1 Not referred
- 2 Private psychiatrist
- 3 Other private medical practitioner
- 4 Mental health/alcohol and drug in-patient facility
- 5 Mental health/alcohol and drug non in-patient facility
- 6 Acute hospital
- 7 Other

### Administrative attributes

*Source organisation:* National minimum data set working parties

#### *National minimum data sets*

Admitted patient mental health care from 01/07/1997 to

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## Separation

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*Admin. status:* CURRENT 1/07/2000

### Identifying and definitional attributes

*Knowledgebase ID:* 000148 Version number: 3

*Data element type:* DATA ELEMENT CONCEPT

*Definition:* Separation is the process by which an episode of care for an admitted patient ceases.

A separation may be formal or statistical.

Formal separation: the administrative process by which a hospital records the cessation of treatment and/or care and/or accommodation of a patient.

Statistical separation: the administrative process by which a hospital records the cessation of an episode of care for a patient within the one hospital stay.

*Context:* Admitted patient care:

### Relational and representational attributes

*Guide for use:* This treatment and/or care provided to a patient prior to separation occurs over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients).

*Related data:* supersedes previous data element Separation, version 2  
relates to Care type, version 4  
relates to concept Admitted patient, version 3  
relates to Separation date, version 5  
relates to concept Admission, version 3

### Administrative attributes

*Source organisation:* National Health Data Committee

*Comments:* While this concept is also applicable to non-admitted patient care and welfare services, different terminology to 'separation' is often used in these other care settings.

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## Separation date

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*Admin. status:* CURRENT 1/07/1999

### Identifying and definitional attributes

*Knowledgebase ID:* 000043 Version number: 5

*Data element type:* DATA ELEMENT

*Definition:* Date on which an admitted patient completes an episode of care.

*Context:* Required to identify the period in which an admitted patient hospital stay or episode occurred and for derivation of length of stay.

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

*Data domain:* Valid dates

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

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

*Related data:* supersedes previous data element Discharge date, version 4

### Administrative attributes

*Source organisation:* National Health Data Committee

#### *National minimum data sets:*

Admitted patient care from 1/07/1999 to

Admitted patient mental health care from 1/07/2000 to

Admitted patient palliative care from 1/07/2000 to

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

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## Separation time

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*Admin. status:* CURRENT 1/07/2001

### Identifying and definitional attributes

*Knowledgebase ID:* 000644 Version number: 1

*Data element type:* DATA ELEMENT

*Definition:* Time at which an admitted patient completes an episode of care.

*Context:* Admitted patient care:

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 4 Max. 4 Layout: HHMM

*Data domain:* Expressed as hours and minutes using 24-hour clock

*Related data:* relates to the data element concept Admitted patient, version 3  
 relates to the data element concept Admission, version 3  
 is used in conjunction with Admission date, version 4  
 is used in conjunction with Admission time, version 2  
 is used in conjunction with Separation date, version 5

### Administrative attributes

*Comments:* Required to identify the time of completion of the episode or hospital stay, for calculation of length of stay.

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## Total leave days

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*Admin. status:* CURRENT 1/07/1996

### Identifying and definitional attributes

*Knowledgebase ID:* 000163 Version number: 3

*Data element type:* DATA ELEMENT

*Definition:* Sum of the length of leave (date returned from leave minus date went on leave) for all periods within the hospital stay.

*Context:* Recording of leave days allows for exclusion of these from the calculation of patient days. This is important for analysis of costs per patient and for planning. The maximum limit allowed for leave affects admission and separation rates, particularly for long-stay patients who may have several leave periods.

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 1 Max. 3 Layout: NNN

*Data domain:* Count is number of days

*Guide for use:* A day is measured from midnight to midnight.  
The following rules apply in the calculation of leave days for both overnight and same-day patients:

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

*Verification rules:* For the provision of State and Territory hospital data to Commonwealth agencies (Date of separation minus Date of admission) minus Total leave days must be  $\geq 0$  days.

*Related data:* supersedes previous data element Total leave days, version 2

### Administrative attributes

*Source organisation:* National Health Data Committee

#### National minimum data sets:

Admitted patient care from 1/07/2000 to

Admitted patient mental health care from 1/07/2000 to

*Comments:* It should be noted that for private patients in public and private hospitals, s.3 (12) of the Health Insurance Act 1973 (Cwlth) currently applies a different leave day count, Commonwealth Department of Human Services and Health HBF Circular 354 (31 March 1994).

This item was modified in July 1996 to exclude the previous differentiation between the psychiatric and other patients.

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## Aged care assessment status

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*Admin. status:* CURRENT 1/07/1989

### Identifying and definitional attributes

*Knowledgebase ID:* 000017 Version number: 1

*Data element type:* DATA ELEMENT

*Definition:* The assessment status of a person in terms of whether or not he or she has been assessed by a regional aged care assessment team and, if so, which one.

*Context:* Aged care assessment: useful variable when comparing resident population across systems.

### Relational and representational attributes

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

*Data domain:*

1	Assessed by approved aged care assessment team
2	Assessed by non-approved aged care assessment team
3	Assessed by Commonwealth medical officer
4	Not assessed
5	Unknown

*Collection methods:* This item is based on the form NH5, which has been replaced.

### Administrative attributes

*Source organisation:* Commonwealth Department of Health and Aged Care

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## Category reassignment date

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*Admin. status:* CURRENT 1/07/1997

### Identifying and definitional attributes

*Knowledgebase ID:* 000391 Version number: 2

*Data element type:* DATA ELEMENT

*Definition:* The date on which a patient awaiting elective hospital care is assigned to a different urgency category as a result of clinical review for the awaited procedure, or is assigned to a different patient listing status category ('ready for care' or 'not ready for care').

*Context:* Elective surgery: this date is necessary for the calculation of Waiting time at admission and Waiting time at a census date.

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

*Data domain:* Valid date

*Guide for use:* The date needs to be recorded each time a patient's urgency classification or listing status changes.

*Related data:* relates to Clinical review, version 1  
used in conjunction with Patient listing status, version 3  
used in conjunction with Clinical urgency, version 2  
supersedes previous data element Urgency reassignment date, version 1  
is used in the calculation of Waiting time at a census date, version 1  
is used in the calculation of Waiting time at admission, version 1

### Administrative attributes

*Source organisation:* AIHW, National Health Data Committee

*National minimum data sets:*

Elective surgery waiting times from 1/07/1994 to

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## Clinical review

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*Admin. status:* CURRENT 1/07/1995

### Identifying and definitional attributes

*Knowledgebase ID:* 000024 Version number: 1

*Data element type:* DATA ELEMENT CONCEPT

*Definition:* The examination of a patient by a clinician after the patient has been added to the waiting list. This examination may result in the patient being assigned a different urgency rating from the initial classification. The need for clinical review varies with a patient's condition and is therefore at the discretion of the treating clinician.

*Context:* Admitted patient care:

### Relational and representational attributes

*Related data:* relates to Clinical urgency, version 1  
relates to Clinical urgency, version 2

### Administrative attributes

*Source organisation:* Hospital Access Program Waiting List Working Group/National Health Data Committee

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## Clinical urgency

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*Admin. status:* CURRENT 1/07/1997

### Identifying and definitional attributes

*Knowledgebase ID:* 000025 Version number: 2

*Data element type:* DATA ELEMENT

*Definition:* A clinical assessment of the urgency with which a patient requires elective hospital care.

*Context:* Elective surgery: categorisation of waiting list patients by clinical urgency assists hospital management and clinicians in the prioritisation of their workloads. It gives health consumers a reasonable estimate of the maximum time they should expect to wait for care.

Clinical urgency classification allows a meaningful measure of system performance to be calculated, namely the number or proportion of patients who wait for times in excess of the maximum desirable time for their urgency category (data element 'Overdue patient').

### Relational and representational attributes

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

*Data domain:*

- 1 Admission within 30 days desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency.
- 2 Admission within 90 days desirable for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly or become an emergency.
- 3 Admission at some time in the future acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency.

*Guide for use:* The classification employs a system of urgency categorisation based on factors such as the degree of pain, dysfunction and disability caused by the condition and its potential to deteriorate quickly into an emergency. All patients ready for care must be assigned to one of the urgency categories, regardless of how long it is estimated they will need to wait for surgery.

*Related data:*

- relates to concept Clinical review, version 1
- supersedes the data element Patient listing status, version 2
- used in conjunction with Patient listing status, version 3
- used in conjunction with Category reassignment date, version 2
- is a qualifier of Overdue patient, version 3
- is a qualifier of Extended wait patient, version 1
- is a qualifier of Waiting time at a census date, version 1
- is a qualifier of Waiting time at admission, version 1

## Administrative attributes

*Source organisation:* National Health Data Committee

*National minimum data sets:*

Elective surgery waiting times from 1/07/1994 to

*Comments:* A patient's classification may change if he or she undergoes clinical review during the waiting period. 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 (data element Category reassignment date).

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## Date of triage

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*Admin. status:* CURRENT 1/07/1998

### Identifying and definitional attributes

*Knowledgebase ID:* 000353 Version number: 1

*Data element type:* DATA ELEMENT

*Definition:* The day on which the patient is triaged.

*Context:* Admitted patient care: Required to identify the commencement of the service and calculation of waiting times.

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

*Data domain:* Valid dates

*Related data:* relates to Emergency Department waiting time to service delivery, version 1  
relates to concept Patient presentation at Emergency Department, version 1  
relates to Time of triage, version 1

### Administrative attributes

*Source organisation:* National Institution Based Ambulatory Model Reference Group; NHDC

#### *National minimum data sets:*

Emergency Department waiting times from 1/07/1999 to

*Comments:* This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department Waiting Times National Minimum Data Set.

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## Level of care

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*Admin. status:* CURRENT 1/07/1989

### Identifying and definitional attributes

*Knowledgebase ID:* 000294 Version number: 1

*Data element type:* DATA ELEMENT

*Definition:* The level of care needed by a patient/resident as assessed by the summation of scores on questions contained in the Resident Classification Instrument and subsequent classification into one of five major categories.

*Context:* Residential aged care services: the level of resources and associated costs of providing care to residential aged care service residents depends on the levels of dependency of the residents. This field is an attempt to measure the levels of care required by individual residents in order that an overall profile of the residential aged care service population can be obtained. Such a profile is necessary to help explain cost variations both between residential aged care services and over time.

At present there is no method of determining the underlying population demand for residential aged care service beds. changes on the level of care required on admission to a residential aged care service may also provide a useful indication of changes in demand.

This data element also provides a summary profile of dependency of resident population, as a basis for monitoring changes in resident profile as a consequence of assessment and other measures being introduced.

### Relational and representational attributes

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

*Data domain:*

1	Very high need
2	High need
3	Medium need
4	Low need
5	Very low need
6	Ordinary care (non-RCI)
7	Extensive care (non-RCI)

*Guide for use:* For State residential aged care services not using Resident Classification Instrument, the level of care as measured by resident classification into ordinary of extensive care.

*Collection methods:* This item is based on the Resident Classification Instrument, which has been replaced.

### Administrative attributes

*Source organisation:* National minimum data set working parties

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## Multi-disciplinary team status

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*Admin. status:* CURRENT 1/07/2000

### Identifying and definitional attributes

*Knowledgebase ID:* 000434 Version number: 1

*Data element type:* DATA ELEMENT

*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:

### Relational and representational attributes

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

*Data domain:*

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

*Related data:*

- used in conjunction with Non-admitted patient service event count, version 1
- used in conjunction with Non-admitted patient service event, version 1
- used in conjunction with Non-admitted patient service type, version 1
- used in conjunction with New/repeat status, version 1, if required
- used in conjunction with Individual/group session, version 1

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## New/repeat status

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*Admin. status:* CURRENT 1/07/2000

### Identifying and definitional attributes

*Knowledgebase ID:* 000435 Version number: 1

*Data element type:* DATA ELEMENT

*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:

### Relational and representational attributes

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

*Data domain:*

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

*Guide for use:* New service events occur as each type of clinical service makes their full assessment consultation with the patient.

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

Examples of clinical services are included in the Guide for use for Non-admitted patient service type.

*Related data:*

- used in conjunction with Non-admitted patient service event, version 1
- used in conjunction with Non-admitted patient service type, version 1
- used in conjunction with Non-admitted patient service mode, version 1
- used in conjunction with Non-admitted patient service event – patient present status, version 1
- used in conjunction with Multi-disciplinary team status, version 1
- used in conjunction with Individual/group session, version 1

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## Non-admitted patient service event—patient present status

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*Admin. status:* CURRENT 1/07/2000

### Identifying and definitional attributes

*Knowledgebase ID:* 000436 Version number: 1

*Data element type:* DATA ELEMENT

*Definition:* The presence or absence of a patient at a non-admitted patient service event.

*Context:* Hospital non-admitted patient care:

### Relational and representational attributes

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

*Data domain:*

- 1 Patient present with or without carer(s)/relative(s)
- 2 Carer(s)/relative(s) of the patient only

*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.

*Related data:*

- used in conjunction with Non-admitted patient service event count, version 1
- used in conjunction with Non-admitted patient service event, version 1
- used in conjunction with Non-admitted patient service type, version 1
- used in conjunction with Non-admitted patient service mode, version 1
- used in conjunction with Multi-disciplinary team status, version 1
- used in conjunction with Individual/group session, version 1

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## Time of triage

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*Admin. status:* CURRENT 1/07/1998

### Identifying and definitional attributes

*Knowledgebase ID:* 000354 Version number: 1

*Data element type:* DATA ELEMENT

*Definition:* The time at which the patient is triaged.

*Context:* Admitted patient care: Required to identify the commencement of the service and calculation of waiting times.

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 4 Max. 4 Layout: HHMM

*Data domain:* Valid value

*Related data:* relates to Admission date, version 3  
 relates to Emergency Department waiting time to service delivery, version 1  
 relates to Emergency Department waiting time to admission, version 1  
 relates to concept Patient presentation at Emergency Department, version 1  
 relates to Date patient presents, version 2  
 relates to Time patient presents, version 2  
 relates to Type of visit to Emergency Department, version 2  
 relates to Date of triage, version 1  
 relates to Triage category, version 1  
 relates to Date of commencement of service event, version 2  
 relates to Time of commencement of service event, version 2  
 relates to Admission time, version 1

### Administrative attributes

*Source organisation:* National Institution Based Ambulatory Model Reference Group; NHDC

*National minimum data sets:*

Emergency Department waiting times from 1/07/1999 to

*Comments:* This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department Waiting Times National Minimum Data Set.

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## Triage category

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*Admin. status:* CURRENT 1/07/1998

### Identifying and definitional attributes

*Knowledgebase ID:* 000355 Version number: 1

*Data element type:* DATA ELEMENT

*Definition:* The urgency of the patient's need for medical and nursing care.

*Context:* Admitted patient healthcare: Required to provide data for analysis of Emergency Department processes.

### Relational and representational attributes

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

*Data domain:*

- 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

*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.

*Related data:*

- relates to Non-admitted patient, version 1
- relates to Admission date, version 3
- supersedes previous data element Triage category (trial), version 1
- relates to Emergency Department waiting time to service delivery, version 1
- relates to Emergency Department waiting time to admission, version 1
- relates to concept Patient presentation at Emergency Department, version 1
- relates to Date patient presents, version 2
- relates to Time patient presents, version 2
- relates to Type of visit to Emergency Department, version 2
- relates to Date of triage, version 1
- relates to Time of triage, version 1
- relates to Date of commencement of service event, version 2
- relates to Time of commencement of service event, version 2
- relates to Admission time, version 1
- relates to Departure status, version 1

## **Administrative attributes**

**Source document:** National Triage Scale, Australasian College for Emergency Medicine (ACEM)

**National minimum data sets:**

Emergency Department waiting times from 1/07/1999 to

**Comments:** This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the Emergency Department Waiting Times National Minimum Data Set.

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## Urgency of admission

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*Admin. status:* CURRENT 1/07/2000

### Identifying and definitional attributes

*Knowledgebase ID:* 000425 Version number: 1

*Data element type:* DATA ELEMENT

*Definition:* Whether the admission has an urgency status assigned and, if so, whether admission occurred on an emergency basis.  
An emergency admission is an admission of a patient for care or treatment which, in the opinion of the treating clinician, is necessary and admission for which should occur within 24 hours.

An elective admission is an admission of a patient for care or treatment which, in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least 24 hours.

Admissions for which an urgency status is usually not assigned are:

- admissions for normal delivery (obstetric);
- admissions which begin with the birth of the patient, or when it was intended that the birth occur in the hospital, commence shortly after the birth of the patient;
- statistical admissions; and
- planned re-admissions for the patient to receive limited care or treatment for a current condition, for example dialysis or chemotherapy.

*Context:* Admitted patient care:

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 1 Max. 3 Layout: N(N)

*Data domain:*

1	Urgency status assigned—emergency
2	Urgency status assigned—elective
3	Urgency status not assigned
9	Not known/not reported

*Guide for use:* Emergency admission

The following guidelines may be used by health professionals, hospitals and health insurers in determining whether an emergency admission has occurred. These guidelines should not be considered definitive.

An emergency admission occurs if one or more of the following clinical conditions are applicable such that the patient required admission within 24 hours.

Such a patient would be:

- at risk of serious morbidity or mortality and requiring urgent assessment and/or resuscitation; or
- suffering from suspected acute organ or system failure; or
- suffering from an illness or injury where the viability or function of a body part or organ is acutely threatened; or
- suffering from a drug overdose, toxic substance or toxin effect; or

*Guide for use  
(continued):*

- experiencing severe psychiatric disturbance whereby the health of the patient or other people is at immediate risk; or
- suffering severe pain where the viability or function of a body part or organ is suspected to be acutely threatened; or
- suffering acute significant haemorrhage and requiring urgent assessment and treatment; or
- suffering gynaecological or obstetric complications; or
- suffering an acute condition which represents a significant threat to the patient's physical or psychological wellbeing; or
- suffering a condition which represents a significant threat to public health.

If an admission meets the definition of emergency above, it is categorised as emergency, regardless of whether the admission occurred within 24 hours of such a categorisation being made, or after 24 hours or more.

Elective admissions

If an admission meets the definition of elective above, it is categorised as elective, regardless of whether the admission actually occurred after 24 hours or more, or it occurred within 24 hours. The distinguishing characteristic is that the admission could be delayed by at least 24 hours.

Scheduled admissions

A patient who expects to have an elective admission will often have that admission scheduled in advance. Whether or not the admission has been scheduled does not affect the categorisation of the admission as emergency or elective, which depends only on whether it meets the definitions above. That is, patients both with and without a scheduled admission can be admitted on either an emergency or elective basis.

Admissions from elective surgery waiting lists

Patients on waiting lists for elective surgery are assigned a Clinical urgency status which indicates the clinical assessment of the urgency with which a patient requires elective hospital care. On admission, they will also be assigned an Urgency of admission category, which may or may not be elective.

Patients who are removed from elective surgery waiting lists on admission as an elective patient for the procedure for which they were waiting (see data domain value 1 in Reason for removal) will be assigned an Urgency of admission of 'Urgency status assigned – elective'. In that case, their Clinical urgency category could be regarded as further detail on how urgent their admission was.

Patients who are removed from elective surgery waiting lists on admission as an emergency patient for the procedure for which they were waiting (see data domain value 2 in Reason for removal), will be assigned an Urgency of admission of 'Urgency status assigned – emergency'.

Admissions for which an urgency status is usually not assigned

An urgency status can be assigned for admissions of the types listed above for which an urgency status is not usually assigned. For example, a patient who is to have an obstetric admission may have one or more of the clinical conditions listed above and be admitted on an emergency basis.

*Guide for use  
(continued):*Use of data domain 9

The not known/not reported category is to be used when it is not known whether or not an urgency status has been assigned, or when an urgency status has been assigned but is not known.

**Administrative attributes**

*Source organisation:* Emergency Definition Working Party, NHDC

*National minimum data sets:*

Admitted patient care from 1/07/2000 to

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## Anticipated patient election status

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*Admin. status:* CURRENT 1/07/2001

### Identifying and definitional attributes

*Knowledgebase ID:* 000631 Version number: 1

*Data element type:* DATA ELEMENT

*Definition:* Accommodation chargeable status nominated by the patient when placed on an elective surgery waiting list.

*Context:* Elective surgery waiting times.

### Relational and representational attributes

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

*Data domain:*  
1 Public  
2 Private

*Guide for use:* The election status nominated by the patient at the time of being placed on an elective surgery waiting list, to be treated as either:

- a public patient; or
- a private patient

This item is independent of patient's hospital insurance status. The definitions of a public and private patient are those in the 1998–2003 Australian Health Care Agreements:

1. Public patient: an eligible person who receives or elects to receive a public hospital service free of charge.
2. Private patient: an eligible person who elects to be treated as a private; and elects to be responsible for paying fees of the type referred to in clause 57 (clause 58 of the Northern Territory Agreement) of the Australian Health Care Agreements.

Clause 57 states that "Private patients and ineligible persons may be charged an amount for public hospital services as determined by the State."

Patients whose charges are to be met by the Department of Veteran's Affairs are regarded as private patients.

### Administrative attributes

*Comments:* Anticipated election status may be used for the management of elective surgery waiting lists, but the term is not defined under the 1998–2003 Australian Health Care Agreements. Under the Agreements patients are required to elect to be treated as a public or private patient, at the time of, or as soon as practicable after admission. Therefore, the anticipated patient election status is not binding on the patient and may vary from the election the patient makes on admission.

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## Intended length of hospital stay

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*Admin. status:* CURRENT 1/07/2001

### Identifying and definitional attributes

*Knowledgebase ID:* 000076 Version number: 2

*Data element type:* DATA ELEMENT

*Definition:* The intention of the responsible clinician at the time of the patient's admission to hospital or at the time the patient is placed on an elective surgery waiting list, to discharge the patient either on the day of admission or a subsequent date.

*Context:* Admitted patient care: to assist in the identification and casemix analysis of planned same-day patients, that is those patients who are admitted with the intention of discharge on the same day. This is also a key indicator for quality assurance activities.

### Relational and representational attributes

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

*Data domain:*  
1 Intended same-day  
2 Intended overnight

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

*Related data:* Is used in the derivation of Diagnosis related group, version 1  
supersedes Intended length of hospital stay, version 1

### Administrative attributes

*Source organisation:* National Health Data Committee

#### *National minimum data sets:*

Admitted patient care from 1/07/2001 to

Admitted patient mental health care from 1/07/2001 to

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

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## Intended place of birth

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*Admin. status:* CURRENT 1/07/1996

### Identifying and definitional attributes

*Knowledgebase ID:* 000077 Version number: 1

*Data element type:* DATA ELEMENT

*Definition:* The intended place of birth at the onset of labour.

*Context:* Perinatal: women who plan to give birth in birth centres or at home usually have different risk factors for outcome compared to those who plan to give birth in hospitals. Women who are transferred to hospital after the onset of labour have increased risks of intervention and adverse outcomes.

### Relational and representational attributes

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

*Data domain:*

1	Hospital, excluding birth centre
2	Birth centre, attached to hospital
3	Birth centre, free standing
4	Home
8	Other
9	Not stated

*Guide for use:*

1	Hospital – includes for women who have elective caesarean sections
4	Home – should be restricted to the home of the woman or a relative or friend.
8	Other – includes community (health) centres.

*Related data:*

- is qualified by Actual place of birth, version 1
- is qualified by Onset of labour, version 2
- is qualified by Method of birth, version 1

### Administrative attributes

*Source organisation:* National Perinatal Data Development Committee

*Comments:* The development of a definition of a birth centre is currently under consideration by the Commonwealth in conjunction with the States and Territories.

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## Scheduled admission date

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*Admin. status:* CURRENT 1/01/1995

### Identifying and definitional attributes

*Knowledgebase ID:* 000147 Version number: 2

*Data element type:* DATA ELEMENT

*Definition:* The date on which it is proposed that a patient on the waiting list will be admitted for an episode of care.

*Context:* This item is required for the purposes of hospital management – allocation of beds, operating theatre time and other resources.

### Relational and representational attributes

*Datatype:* Numeric Field size: Min. 8 Max. 8 Layout: DDMMYYYY

*Data domain:* Valid dates

*Related data:* supersedes previous data element Scheduled admission date, version 1  
used in conjunction with Listing date for care, version 3

### Administrative attributes

*Source organisation:* National Health Data Committee

*Comments:* If this data element were to be used to compare different hospitals or geographical locations, it would be necessary to specify when the scheduled date is to be allocated (for example, on addition to the waiting list).