

Data elements

D – E

Date of birth

Identifying and Definitional Attributes

Knowledgebase ID:	000036	Version No:	4
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/03		
Definition:	The date of birth of the person.		
Context:	Required to derive age at a point of time for clinical or administrative use. National Minimum Data Sets: Used for demographic analyses, for analysis by age and for use to derive a diagnosis related group (admitted patients). NMDS - Perinatal: Requires the collection of the date of birth for the mother and the baby(s).		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Date
Representational layout:	DDMMYYYY
Minimum size:	8
Maximum size:	8
Data domain:	Valid date
Guide for use:	If date of birth is not known, provision should be made to collect age (in years) and a date of birth derived from age.
Verification rules:	This field must not be null. National Minimum Data Sets: For the provision of State and Territory hospital data to Commonwealth agencies this field must: <ul style="list-style-type: none"> - be less than or equal to Admission date, Date patient presents or Service contact date - be consistent with diagnoses and procedure codes, for records to be grouped.
Collection methods:	It is recommended that in cases where all components of the date of birth are not known or where an estimate is arrived at from age, a valid date be used together with a flag to indicate that it is an estimate. NMDS - Perinatal: Data collection systems must be able to differentiate between the date of birth of the mother and the baby(s). This is important in the Perinatal data collection as the date of birth of the baby is used to determine the antenatal length of stay and the postnatal length of stay.
Related metadata:	supersedes previous data element Date of birth vers 3 is used in the derivation of Diagnosis related group vers 1 is qualified by Estimated date flag vers 1 is used in the calculation of Length of stay (antenatal) vers 1 is used in the calculation of Length of stay (postnatal) vers 1

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Demographic characteristic

Data Set Specifications:	Start date	End date
NMDS - Admitted patient care	01/07/2003	
NMDS - Admitted patient mental health care	01/07/2003	
NMDS - Admitted patient palliative care	01/07/2003	
NMDS - Alcohol and other drug treatment services	01/07/2003	
NMDS - Community mental health care	01/07/2003	
NMDS - Health labour force	01/07/2003	
NMDS - Non-admitted patient emergency department care	01/07/2003	
NMDS - Perinatal	01/07/2003	
DSS - Cardiovascular disease (clinical)	01/01/2003	
DSS - Diabetes (clinical)	01/01/2003	
DSS - Health care client identification	01/01/2003	

Comments:

Any new information collections should allow for 0000YYYY. (Refer Standards Australia, AS5017 Health care client identification).

Do not use punctuation (slashes or hyphens) or spaces.

In cases where all components of the date of birth are not known or where an estimate is arrived at from age, use 00 for day and 00 for month and estimate year of birth according to the person's approximate age. As soon as known or on re-presentation, always update the Date of Birth (DOB) field. The use of the Estimated date flag is also to be used to signify that an estimate is being made.

DSS - Cardiovascular disease (clinical):

Age is an important non-modifiable risk factor for cardiovascular conditions. The prevalence of cardiovascular conditions increases dramatically with age. For example, more than 60% of people aged 75 and over had a cardiovascular condition in 1995 compared with less than 9% of those aged under 35.

Aboriginal and Torres Strait Islander peoples are more likely to have cardiovascular conditions than other Australians across almost all age groups. For example, in the 25-44 age group, 23% of Indigenous Australians reported cardiovascular conditions compared with 16% among other Australians (Heart, Stroke and Vascular Diseases: Australian Facts 2001. AIHW).

DSS - Diabetes (clinical):

Age over 45 is one of the predisposing factors for developing Type 2 diabetes and age over 35 in individuals of Aboriginal and Torres Strait Islander and certain other ethnic origins. The prevalence of diabetes increases with age, approaching 25% among those over 75.

References:

National Institute of Aging U. S. Department of Health and Human Services
NHMRC Evidence Based Guidelines for Case Detection and Diagnosis of Type 2 Diabetes

Date of cessation of treatment episode for alcohol and other drugs

Identifying and Definitional Attributes

Knowledgebase ID:	000424	Version No:	2
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/01		
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
Representational form:	Date
Representational layout:	DDMMYYYY
Minimum size:	8
Maximum size:	8
Data domain:	Valid date
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.
Collection methods:	
Related metadata:	relates to the data element concept Cessation of treatment episode for alcohol and other drugs vers 2 supersedes previous data element Date of cessation of treatment vers 1 relates to the data element Reason for cessation of treatment episode for alcohol and other drugs vers 2

Administrative Attributes

Source document:		
Source organisation:	Intergovernmental Committee on Drugs NMDS – WG	
Information model link:	NHIM Exit/leave from service event	
Data Set Specifications:	Start date	End date
NMDS – Alcohol and other drug treatment services	01/07/2001	
Comments:		

Date of change to qualification status

Identifying and Definitional Attributes

Knowledgebase ID:	000342	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/98		
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.		

Context:

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Date
Representational layout:	DDMMYYYY
Minimum size:	8
Maximum size:	8
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
Collection methods:	
Related metadata:	is used in conjunction with Admitted patient vers 3 is used in the calculation of Number of qualified days for newborns vers 2 is used in conjunction with Newborn qualification status vers 2 is used in conjunction with Care type vers 4

Administrative Attributes

Source document:		
Source organisation:		
Information model link:		
NHIM Service provision event		
Data Set Specifications:	Start date	End date
Comments:		

Date of commencement of service event

Identifying and Definitional Attributes

Knowledgebase ID:	000356	Version No: 2
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/01	
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 and public health care.	

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Date
Representational layout:	DDMMYYYY
Minimum size:	8
Maximum size:	8
Data domain:	Valid dates
Guide for use:	For the emergency departments 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.
Verification rules:	
Collection methods:	
Related metadata:	<ul style="list-style-type: none"> supersedes previous data element Date of service event vers 1 relates to the data element Date of triage vers 1 relates to the data element Date patient presents vers 2 relates to the data element Emergency department waiting time to admission vers 1 relates to the data element Emergency department waiting time to service delivery vers 2 relates to the data element concept Patient presentation at emergency department vers 1 relates to the data element Time of commencement of service event vers 2 relates to the data element Time of triage vers 1 relates to the data element Time patient presents vers 2

Administrative Attributes

Source document:	
Source organisation:	National Institution Based Ambulatory Model Reference Group National Health Data Committee

Information model link:

NHIM Request for/entry into service event

Data Set Specifications:

NMDS - Emergency department waiting times

Start date**End date**

01/07/2001

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 NMDS - Emergency department waiting times.

Date of commencement of treatment episode for alcohol and other drugs

Identifying and Definitional Attributes

Knowledgebase ID:	000430	Version No:	2
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/01		
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
Representational form:	Date
Representational layout:	DDMMYYYY
Minimum size:	8
Maximum size:	8
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.
Collection methods:	
Related metadata:	relates to the data element concept Commencement of treatment episode for alcohol and other drugs vers 2 supersedes previous data element Date of commencement of treatment vers 1

Administrative Attributes

Source document:			
Source organisation:	Intergovernmental Committee on Drugs NMDS WG		
Information model link:	NHIM Request for/entry into service event		
Data Set Specifications:		Start date	End date
NMDS - Alcohol and other drug treatment services		01/07/2001	
Comments:			

Date of completion of last previous pregnancy

Identifying and Definitional Attributes

Knowledgebase ID:	000037	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/96		
Definition:	Date on which the pregnancy preceding the current pregnancy was completed.		
Context:	Perinatal statistics: Interval between pregnancies may be an important risk factor for the outcome of the current pregnancy, especially for preterm birth and low birthweight.		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Date
Representational layout:	DDMMYYYY
Minimum size:	8
Maximum size:	8
Data domain:	Valid date
Guide for use:	Estimate day of month (DD), if first day is unknown.
Verification rules:	
Collection methods:	
Related metadata:	is qualified by Outcome of last previous pregnancy vers 1 is a qualifier of Previous pregnancies vers 1

Administrative Attributes

Source document:			
Source organisation:	National Perinatal Data Development Committee		
Information model link:	NHIM Physical wellbeing		
Data Set Specifications:		Start date	End date
Comments:	This data item is recommended by the World Health Organization. It is currently collected in some States and Territories.		

Date of diagnosis

Identifying and Definitional Attributes

Knowledgebase ID: 000666 **Version No:** 1

Metadata type: Data Element

Admin. status: Current
01/01/03

Definition: The date a disease or condition is diagnosed.

Context: Health services and clinical setting:
Diagnostic information provides the basis for analysis of health service usage, epidemiological studies and monitoring of specific disease entities and conditions.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Date

Representational layout: DDMMYYYY

Minimum size: 8

Maximum size: 8

Data domain: Valid date

Guide for use:

Verification rules:

Collection methods:

Related metadata: relates to the data element Diabetes status vers 1
relates to the data element concept Diagnosis vers 1
is used in conjunction with Service contact date vers 1
relates to the data element Vascular history vers 1
relates to the data element Vascular procedures vers 1

Administrative Attributes

Source document:

Source organisation: CV-Data Working Group

Information model link:

NHIM Service provision event

Data Set Specifications:	Start date	End date
DSS - Cardiovascular disease (clinical)	01/01/2003	

Comments: Classification systems, which enable the allocation of a code to the diagnostic information, can be used in conjunction with this data element.

Date of diagnosis of cancer

Identifying and Definitional Attributes

Knowledgebase ID:	000771	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/02		
Definition:	The date when the cancer was first diagnosed (whether at its primary site or as a metastasis).		
Context:	Patient administration systems, cancer notification systems, population cancer statistics, research.		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Date
Representational layout:	DDMMYYYY
Minimum size:	8
Maximum size:	8

Data domain: Valid date

Guide for use: Date of diagnosis must be:
 >= Date of birth
 <= Date of death
 Diagnosis of cancer after death:
 If the patient is first diagnosed with the cancer in an autopsy report the date of diagnosis is the date of death as stated on the patient's death certificate.
 Incidental diagnosis of cancer:
 If a patient is admitted for another condition (e.g. a broken leg or pregnancy), and a cancer is diagnosed incidentally then the date of diagnosis is the date the cancer was diagnostically determined, not the admission date.

Verification rules:

Collection methods: Reporting rules:
 The date of diagnosis is the date of the pathology report, if any, that first confirmed the diagnosis of cancer. This date may be found attached to a letter of referral or a patient's medical record from another institution or hospital. If this date is unavailable, or if no pathological test was done, then the date may be determined from one of the sources listed in the following sequence:
 Date of the consultation at, or admission to, the hospital, clinic or institution when the cancer was first diagnosed. Note: DO NOT use the admission date of the current admission if the patient had a prior diagnosis of this cancer.
 Date of first diagnosis as stated by a recognised medical practitioner or dentist. Note: This date may be found attached to a letter of referral or a patient's medical record from an institution or hospital.
 Date the patient states they were first diagnosed with cancer. Note: This may be the only date available in a few cases (for example, patient was first diagnosed in a foreign country).

If components of the date are not known, an estimate should be provided where possible with an estimated date flag to indicate that it is estimated. If an estimated date is not possible, a standard date of 15 June 1900 should be used with a flag to indicate the date is not known.

Related metadata: relates to the data element Date of birth vers 4
relates to the data element Estimated date flag vers 1

Administrative Attributes

Source document: Modified from the definition presented by the New South Wales Inpatient Statistics Collection Manual 2000/2001

Source organisation: International Agency for Research on Cancer
World Health Organization
International Association of Cancer Registries.

Information model link:

NHIM Request for/entry into service event

Data Set Specifications: **Start date** **End date**

Comments:

Date of first contact

Identifying and Definitional Attributes

Knowledgebase ID:	000039	Version No:	2
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/98		
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:		
	<ul style="list-style-type: none"> - 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:		
	<ul style="list-style-type: none"> - 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
Representational form:	Date
Representational layout:	DDMMYYYY
Minimum size:	8
Maximum size:	8
Data domain:	Valid date
Guide for use:	
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 metadata:	<p>supersedes previous data element Date of first contact with the community nursing service vers 1</p> <p>relates to the data element Date of last contact vers 2</p>

Administrative Attributes

Source document:

Source organisation: Australian Council of Community Nursing Services

Information model link:

NHIM Request for/entry into service event

Data Set Specifications:

Start date

End date

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.

Date of first delivery of service

Identifying and Definitional Attributes

Knowledgebase ID:	000038	Version No: 2
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/98	
Definition:	The date of first delivery of service to a person in a non-institutional setting. The definition excludes: <ul style="list-style-type: none"> - visit 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
Representational form:	Date
Representational layout:	DDMMYYYY
Minimum size:	8
Maximum size:	8
Data domain:	Valid dates
Guide for use:	
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 metadata:	supersedes previous data element Date of first community nursing visit vers 1

Administrative Attributes

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

Information model link:

NHIM Request for/entry into service event

Data Set Specifications:*Start date**End date***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.

Date of last contact

Identifying and Definitional Attributes

Knowledgebase ID:	000040	Version No: 2
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/98	
Definition:	Date of the last contact between a staff member of the community service and a person in any setting.	
	The definition includes:	
	<ul style="list-style-type: none"> - 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:	
	<ul style="list-style-type: none"> - 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
Representational form:	Date
Representational layout:	DDMMYYYY
Minimum size:	8
Maximum size:	8
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
Collection methods:	
Related metadata:	relates to the data element Date of first contact vers 2 supersedes previous data element Date of last community service contact with client/family vers 1

Administrative Attributes

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

Information model link:

NHIM Exit/leave from service event

Data Set Specifications:**Start date****End date****Comments:**

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.

Date of procedure

Identifying and Definitional Attributes

Knowledgebase ID:	000772	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/02		
Definition:	The date on which a procedure commenced during an inpatient episode of care.		
Context:	Admitted patient care:		
	Required to provide information on the timing of the procedure in relation to the episode of care		

Relational and Representational Attributes

Datatype:	Numeric		
Representational form:			
Representational layout:	DDMMYYYY		
Minimum size:	8		
Maximum size:	8		
Data domain:	Valid date		
Guide for use:	Admitted patients: Record date of procedure for all procedures undertaken during an episode of care in accordance with ICD-10-AM 3rd edition.		
Verification rules:			
Collection methods:	Right justified and zero filled (e.g. 1 May 2001 should read 01052001) Date of procedure >= admission date Date of procedure <= separation date		
Related metadata:	relates to the data element Procedure vers 5		

Administrative Attributes

Source document:			
Source organisation:	National Centre for Classification in Health		
Information model link:	NHIM Service provision event		
Data Set Specifications:		Start date	End date
Comments:	The National Centre for Classification in Health advises the National Health Data Committee of relevant changes to the ICD-10-AM Reference: Australian Institute of Health and Welfare (AIHW) 2000. Australian hospital statistics 1998-1999. AIHW cat. no. HSE 11. Canberra: AIHW (Health Services Series no. 15)		

Date of referral to rehabilitation

Identifying and Definitional Attributes

Knowledgebase ID:	000656	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	The date on which a person is referred to a rehabilitation service.		
Context:	Clinical settings.		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Date
Representational layout:	DDMMYYYY
Minimum size:	8
Maximum size:	8
Data domain:	Valid date
Guide for use:	If date of referral is not known then provision should be made to collect month and year as a minimum, using 01 as DD if only the month and year are known.
Verification rules:	
Collection methods:	To be collected at the time of commencement of rehabilitation.
Related metadata:	relates to the data element Date of diagnosis vers 1 relates to the data element Vascular history vers 1 relates to the data element Vascular procedures vers 1

Administrative Attributes

Source document:		
Source organisation:	CV-Data Working Group	
Information model link:	NHIM Service provision event	
Data Set Specifications:		Start date End date
DSS – Cardiovascular disease (clinical)		01/01/2003
Comments:	Required to derive those referred to a rehabilitation service from those eligible to attend and who actually attend. This data element can be used to determine the time lag between referral and commencement of rehabilitation.	

Date of triage

Identifying and Definitional Attributes

Knowledgebase ID: 000353 **Version No:** 1

Metadata type: Data Element

Admin. status: Current
01/07/98

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

Representational form: Date

Representational layout: DDMMYYYY

Minimum size: 8

Maximum size: 8

Data domain: Valid date

Guide for use:

Verification rules:

Collection methods:

Related metadata: relates to the data element Emergency department waiting time to service delivery vers 2
relates to the data element concept Patient presentation at emergency department vers 1
relates to the data element Time of triage vers 1

Administrative Attributes

Source document:

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

Information model link:

NHIM Assessment event

Data Set Specifications:	Start date	End date
NMDS - Emergency department waiting times	01/07/1999	

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 NMDS - Emergency department waiting times.

Date patient presents

Identifying and Definitional Attributes

Knowledgebase ID:	000350	Version No:	2
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/01		
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
Representational form:	Date
Representational layout:	DDMMYYYY
Minimum size:	8
Maximum size:	8

Data domain: Valid date

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).

Verification rules:

Collection methods:

Related metadata:

- relates to the data element Admission date vers 4
- relates to the data element Date of commencement of service event vers 2
- relates to the data element Date of triage vers 1
- supersedes previous data element Date patient presents vers 1
- relates to the data element Emergency department waiting time to admission vers 1
- relates to the data element Emergency department waiting time to service delivery vers 2

relates to the data element concept Patient presentation at emergency department vers 2

relates to the data element Time of commencement of service event vers 2

relates to the data element Time of triage vers 1

relates to the data element Time patient presents vers 2

relates to the data element Triage category vers 2

relates to the data element Type of visit to emergency department vers 2

Administrative Attributes

Source document:

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

Information model link:

NHIM Request for/entry into service event

<i>Data Set Specifications:</i>	<i>Start date</i>	<i>End date</i>
NMDS - Emergency department waiting times	01/07/2001	
NMDS - Non-admitted patient emergency department care	01/07/2003	

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 NMDS - Emergency department waiting times.

Day program attendances

Identifying and Definitional Attributes

Knowledgebase ID: 000211 **Version No:** 1

Metadata type: Derived Data Element

Admin. status: Current
01/07/89

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

Representational form: Quantitative value

Representational layout: NNNNN

Minimum size: 1

Maximum size: 5

Data domain: Number of attendances

Guide for use:

Verification rules:

Collection methods:

Related metadata:

Administrative Attributes

Source document:

Source organisation: National minimum data set working parties

Information model link:

NHIM Service provision event

Data Set Specifications: **Start date** **End date**

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.

Department of Veterans' Affairs file number

Identifying and Definitional Attributes

Knowledgebase ID:	000204	Version No:	2
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/02		
Definition:	A unique number issued to a veteran by the Department of Veterans' Affairs.		
Context:	This number must be recorded by a service provider each time a service is provided to a person who holds the entitlement for reimbursement purposes.		

Relational and Representational Attributes

Datatype:	Alphanumeric
Representational form:	Identification number
Representational layout:	AAANNNNNA
Minimum size:	9
Maximum size:	9

Data domain: Valid identification number

Guide for use: All veterans and veteran community clients are issued with a DVA File Number. The veteran community may access many different benefits, ranging from pensions to health services, through their DVA File Number.

The DVA File Number should only be collected from persons eligible to receive health services that are to be funded by the DVA. The number may be reported to the appropriate government agency to reconcile payment for the service provided.

1st character is the State Code (an alpha) – N, V, Q, W, S or T for the appropriate State/Territory. ACT is included in NSW (N) and NT with SA (S).

Next 7 characters are the File Number, made up of:
War Code + numeric digits, where:
if War Code is 1 alpha character, add 6 digits (ANNNNNN)
if War Code is 2 alpha characters, add 5 digits (AANNNNN)
if War Code is 3 alpha characters, add 4 digits (AAANNNN)

9th character is the Segment Link (an alpha) which represent members related to the veteran. The alpha code is generated in the order that cards are issued. For example A, B, C, D etc.

CAUTIONARY NOTE: For Veterans the 9th character is left blank.

Note that Veterans may have a Medicare Card Number and a Department of Veterans' Affairs (DVA) Number or only a DVA Number.

DVA card number:

This number is the digitised version of the file number. If paper claims are optically scanned by the Health Insurance Commission, the digitised version of the file number is picked up by the scanner and converted to the normal file number format. For manual claims, the Gold and White cards may be used in conjunction with the data element an imprinter.

This method records the DVA file number and other card details on a manual voucher.

The data should not be used by private sector organisations for any purpose unless specifically authorised by law. For example, private sector organisations should not use the DVA File Number for data linking unless specifically authorised by law.

Verification rules:

Collection methods:

Related metadata: supersedes previous data element Department of Veterans' Affairs file number vers 1
relates to the data element Department of Veterans' Affairs patient vers 1

Administrative Attributes

Source document:

Source organisation: Department of Veterans' Affairs

Information model link:

NHIM Recipient role

Data Set Specifications: **Start date** **End date**

Comments:

DVA has three (3) types of health cards:

- Gold Card
- White Card
- Repatriation Pharmaceutical Benefits Card.

Each card indicates, to the health provider, the level of health services the holder is eligible for, at the DVA expense.

The Gold Card enables the holder to access a comprehensive range of health care and related services, for all conditions, whether they are related to war service or not.

The White Card enables the holder to access health care and associated services for war or service-related conditions. Veterans of Australian forces may also be issued this card to receive treatment for malignant cancer, pulmonary tuberculosis and post-traumatic stress disorder and, for Vietnam veterans only, anxiety or depression, irrespective of whether these conditions are related to war service or not.

The White Card holders are eligible to receive, for specific conditions, treatment from registered medical, hospital, pharmaceutical, dental and allied health care providers with whom DVA has arrangements.

A White Card is also issued to eligible ex-service personnel who are from other countries, which enter into arrangements with the Australian government for the treatment of the conditions that these countries accept as war-related.

When a Gold/White Card holder accesses health services at DVA expense, the DVA File Number is critical and should be used. The person's Medicare Card Number is not required or relevant.

It should be noted that there are a number of Gold Card holders who do not have a Medicare Card.

The Repatriation Pharmaceutical Benefits Card is an orange coloured card issued to eligible veterans and merchant mariners from Britain and the Commonwealth and other allied countries. This card enables the holder to access the range of pharmaceutical items available under the Repatriation Pharmaceutical Benefits Scheme. It does not provide access to other health services.

Department of Veterans' Affairs patient

Identifying and Definitional Attributes

Knowledgebase ID:	000421	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/00		
Definition:	An eligible person whose charges for this hospital admission are met by the Department of Veterans' Affairs (DVA).		
Context:	Health services: To assist in analyses of utilisation and health care funding.		

Relational and Representational Attributes

Datatype:	Numeric		
Representational form:	Code		
Representational layout:	N		
Minimum size:	1		
Maximum size:	1		
Data domain:	1	Yes	
	2	No	
Guide for use:	Refer to the <i>Veterans' Entitlements Act 1986</i> for details of eligible DVA beneficiaries.		
Verification rules:			
Collection methods:	Whether or not charges for this episode of care are met by the DVA is routinely established as part of hospital admission processes.		
Related metadata:	relates to the data element Department of Veterans' Affairs file number vers 2 supersedes previous data element Patient accommodation eligibility status vers 2		

Administrative Attributes

Source document:			
Source organisation:			
Information model link:	NHIM Insurance/benefit characteristic		
Data Set Specifications:	Start date	End date	
NMDS - Non-admitted patient emergency department care	01/07/2003		
NMDS - Admitted patient care	01/07/2000	30/06/2001	
NMDS - Admitted patient mental health care	01/07/2000	30/06/2001	

Comments:

Eligible veterans and war widow/widowers can receive free treatment at any public hospital, former Repatriation Hospitals (RH) or a Veteran Partnering (VP) contracted private hospital as a private patient in a shared ward, with the doctor of their choice. Admission to a public hospital does not require prior approval from the DVA.

When treatment cannot be provided within a reasonable time in the public health system at a former RH or a private VP hospital, there is a system of contracted non-VP private hospitals which will provide care.

Admission to a contracted private hospital requires prior financial authorisation from DVA. Approval may be given to attend a non-contracted private hospital when the service is not available at a public or contracted non-VP private hospital.

In an emergency a Repatriation patient can be admitted to the nearest hospital, public or private, without reference to DVA.

If an eligible veteran or war widow/widower chooses to be treated under Veterans' Affairs arrangements, which includes obtaining prior approval for non-VP private hospital care, DVA will meet the full cost of their treatment.

Dependency in activities of daily living

Identifying and Definitional Attributes

Knowledgebase ID:	000309	Version No:	2
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/98		
Definition:	An indicator of a person's ability to carry out activities of daily living without assistance.		

Context: Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding. The following is an example of the minimum items, which are indicative of dependency.

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	NNN
Minimum size:	1
Maximum size:	3

Data domain:	a) Mobility* 1 2 3 4
	b) Toileting 1 2 3 4
	c) Transferring 1 2 3 4 5
	d) Bathing 1 2 3 4
	e) Dressing 1 2 3 4
	f) Eating 1 2 3 4 5
	g) Bed mobility 1 2 3 4 5
	h) Bladder continence 1 2 3 4 5 6
	i) Bowel continence 1 2 3 4 5
	j) Extra surveillance* 1 2 3 4 5 6 7
	k) Technical care** not required, or time in minutes

Guide for use: Services may elect to adopt the measures as defined in this item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

All items must be completed.

Select the appropriate code from the options provided for activities a) to g) when:

- 1 = Independent
- 2 = Requires observation or rare physical assistance
- 3 = Cannot perform the activity without some assistance
- 4 = Full assistance required (totally dependent); for bed mobility – a hoist is used
- 5 = For transferring – person is bedfast; for eating – tube-fed only; for bed mobility – 2 persons physical assist is required

* applies to walking, walking aid or wheelchair

Select the appropriate code for h) Bladder continence when:

- 1 = Continent of urine (includes independence in use of device)
- 2 = Incontinent less than daily
- 3 = Incontinent once per 24 hour period
- 4 = Incontinent 2 – 6 times per 24 hour period
- 5 = Incontinent more than 6 times per 24 hour period
- 6 = Incontinent more than once at night only

Select the appropriate code for l) Bowel continence when:

- 1 = Continent of faeces (includes independence in use of device)
- 2 = Incontinent less than daily
- 3 = Incontinent once per 24 hour period
- 4 = Incontinent regularly, more than once per 24 hour period
- 5 = Incontinent more than once at night only

Select the appropriate code for j) Extra surveillance* when:

- 1 = No additional attention required
- 2 = Less than 30 minutes individual attention per day
- 3 = More than 30 and more than or equal to 90 minutes individual attention per day
- 4 = Requires at least two hours intervention per week on an episodic basis
- 5 = More than 90 minutes but less than almost constant individual attention
- 6 = Requires almost constant individual attention
- 7 = Cannot be left alone at all

* Extra surveillance refers to behaviour, which requires individual attention and/or planned intervention. Some examples of extra surveillance are:

- aggressiveness
- wandering
- impaired memory or attention
- disinhibition and other cognitive impairment.

Select the appropriate code for k) Technical care** not required, or time in minutes, when:

- 1 = No technical care requirements

or

- ____ = Daytime technical (minutes per week)
- ____ = Evening technical (minutes per week)
- ____ = Night-time technical (minutes per week)
- ____ = Infrequent technical (minutes per month)

** Technical care refers to technical tasks and procedures for which nurses receive specific education and which require nursing knowledge of expected therapeutic effect, possible side-effects, complications and appropriate actions related to each. In the community nursing setting, carers may undertake some of these activities within, and under surveillance, of a nursing care-plan.

Some examples of technical care activities are:

- medication administration (including injections)
- dressings and other procedures
- venipuncture
- monitoring of dialysis
- implementation of pain management technology.

Verification rules:

Collection methods: Commencement of Care episode. (There may be several visits in which assessment data are gathered.)

Related metadata: supersedes previous data element Client dependency vers 1

Administrative Attributes

Source document:

Source organisation: Australian Council of Community Nursing Services

Information model link:

NHIM Functional wellbeing

Data Set Specifications: *Start date* *End date*

Comments: There are a significant number of dependency instruments in use in the community and institutional care. The CNMDSA recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The data domain specified in this item consists of a number of standard elements, which can be used to map to and/or score from the majority of them.

Depreciation

Identifying and Definitional Attributes

Knowledgebase ID: 000246 **Version No:** 1

Metadata type: Data Element

Admin. status: Current
01/07/89

Definition: Depreciation represents the expensing of a long-term asset over its useful life and is related to the basic accounting principle of matching revenue and expenses for the financial period. Depreciation charges for the current financial year only should be shown as expenditure. Where intangible assets are amortised (such as with some private hospitals) this should also be included in recurrent expenditure.

Context: Health expenditure:
This item has been retained for national minimum data sets because of its significance for the private sector. Current period depreciation charges form a significant component of expenditure for any health establishment whose financial statements are based on accrual accounting.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Currency

Representational layout: \$999,999,999

Minimum size: 2

Maximum size: 12

Data domain: Australian dollars. Rounded to nearest whole dollar.

Guide for use: Record values up to hundreds of millions of dollars.

Verification rules:

Collection methods:

Related metadata: relates to the data element Establishment type vers 1

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Recurrent expenditure

Data Set Specifications:	Start date	End date
NMDS - Public hospital establishments	01/07/1989	

Comments: With the long-term trend towards accrual accounting in the public sector, this item will ultimately become significant for public sector establishments. Public sector establishments in some States have adopted modified accrual accounting identifying depreciation only, before reaching full accrual accounting. Depreciation is now reported for most public sector establishments and should be reported as a separate recurrent expenditure. Depreciation should be identified separately from other recurrent expenditure categories.

Diabetes status

Identifying and Definitional Attributes

Knowledgebase ID:	000654	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	Identifies a person with or at risk of diabetes.		
Context:	Public health, health care and clinical settings.		

Relational and Representational Attributes

Datatype:	Numeric		
Representational form:	Code		
Representational layout:	NN		
Minimum size:	2		
Maximum size:	2		
Data domain:	01	Type 1 diabetes	
	02	Type 2 diabetes	
	03	Gestational diabetes mellitus (GDM)	
	04	Other (secondary diabetes)	
	05	Previous gestational diabetes mellitus (GDM)	
	06	Impaired fasting glucose (IFG)	
	07	Impaired glucose tolerance (IGT)	
	08	Not diagnosed with diabetes	
	09	Not assessed	
	99	Not stated/inadequately described	

Guide for use: Note that where there is a GDM or Previous GDM (i.e. data domains 3 & 5) and a current history of Type 2 diabetes then record 'Code 2' Type 2 diabetes.

This same principle applies where a history of either IFG (impaired fasting glycaemia) or IGT (impaired glucose tolerance) and a current history and Type 2 diabetes, then record 'Code 2' Type 2 diabetes.

Code 01 Type 1 diabetes:

Beta-cell destruction, usually leading to absolute insulin deficiency. Includes those cases attributed to an autoimmune process, as well as those with beta-cell destruction and who are prone to ketoacidosis for which neither an aetiology nor pathogenesis is known (idiopathic). It does not include those forms of beta-cell destruction or failure to which specific causes can be assigned (e.g. cystic fibrosis, mitochondrial defects). Some subjects with this Type can be identified at earlier clinical stages than 'diabetes mellitus'.

Code 02 Type 2 diabetes:

Type 2 includes the common major form of diabetes, which results from defect(s) in insulin secretion, almost always with a major contribution from insulin resistance.

Code 03 Gestational diabetes mellitus (GDM):

GDM is a carbohydrate intolerance resulting in hyperglycaemia of variable severity with onset or first recognition during pregnancy. The definition

applies irrespective of whether or not insulin is used for treatment or the condition persists after pregnancy. Diagnosis is to be based on the Australian Diabetes in Pregnancy Society (ADIPS) Guidelines.

Code 04 Other (Secondary diabetes):

This categorisation include less common causes of diabetes mellitus, but are those in which the underlying defect or disease process can be identified in a relatively specific manner. They include, for example, genetic defects of beta-cell function, genetic defects in insulin action, diseases of the exocrine pancreas, endocrinopathies, drug or chemical-induced, infections, uncommon forms of immune-mediated diabetes, other genetic syndromes sometimes associated with diabetes.

Code 05 Previous GDM:

Where the person has a history of GDM.

Code 06 Impaired fasting glycaemia (IFG):

IFG or 'non-diabetic fasting hyperglycaemia' refers to fasting glucose concentrations, which are lower than those required to diagnose diabetes mellitus but higher than the normal reference range. An individual is considered to have IFG if they have a fasting plasma glucose of 6.1 or greater and less than 7.0 mmol/L if challenged with an oral glucose load, they have a fasting plasma glucose concentration of 6.1 mmol/L or greater, but less than 7.0 mmol/L, AND the 2 hour value in the Oral Glucose Tolerance Test (OGTT) is less than 7.8 mmol/L.

Code 07 Impaired glucose tolerance (IGT):

IGT is categorised as a stage in the natural history of disordered carbohydrate metabolism; subjects with IGT have an increased risk of progressing to diabetes. IGT refers to a metabolic state intermediate between normal glucose homeostasis and diabetes. Those individuals with IGT manifest glucose intolerance only when challenged with an oral glucose load. IGT is diagnosed if the 2 hour value in the OGTT is greater than 7.8 mmol/L. and less than 11.1 mmol/L AND the fasting plasma glucose concentration is less than 7.0 mmol/L.

Code 08 Not diagnosed with diabetes:

The subject has no known diagnosis of Type 1, Type 2, GDM, Previous GDM, IFG, IGT or Other (secondary diabetes).

Code 09 Not assessed:

The subject has not had their diabetes status assessed.

Code 99 is for unknown or information unavailable.

Verification rules:

Collection methods:

The diagnosis is derived from and must be substantiated by clinical documentation.

DSS - Diabetes (clinical):

A type of diabetes should be recorded and coded for each episode of patient care.

Related metadata:

relates to the data element Date of diagnosis vers 1

relates to the data element Diabetes therapy type vers 1

is used in conjunction with Service contact date vers 1

Administrative Attributes

Source document:

Developed based on Definition, Diagnosis and Classification of Diabetes Mellitus and its Complications Part 1: Diagnosis and Classifications of Diabetes Mellitus Provisional Report of a WHO Consultation (Alberti & Zimmet 1998).

Source organisation:

CV-Data Working Group

National Diabetes Data Working Group

Information model link:

NHIM Physical wellbeing

Data Set Specifications:

	<i>Start date</i>	<i>End date</i>
DSS - Cardiovascular disease (clinical)	01/01/2003	
DSS - Diabetes (clinical)	01/01/2003	

Comments:

DSS - Cardiovascular disease (clinical):

People with diabetes have two to five times increased risk of developing heart, stroke and vascular disease (Zimmet & Alberti 1997). Cardiovascular disease is the most common cause of death in people with diabetes.

Diabetes is also an important cause of stroke, and people with diabetes may have a worse prognosis after stroke.

Heart, stroke and vascular disease and diabetes share common risk factors, but also diabetes is an independent risk factor for heart, stroke and vascular disease.

During the 1995 National Health Survey, about 15 per cent of those with diabetes reported having heart disease, at almost six times the rate noted among people without diabetes. In 1996-97, almost one in six hospital separations, with coronary heart disease as any listed diagnosis, also had diabetes recorded as an associated diagnosis. Heart disease appears earlier in life and is more often fatal among those with diabetes.

Diabetes may accentuate the role of elevated blood pressure in stroke. The incidence and prevalence of peripheral vascular disease in those with diabetes increase with the duration of the diabetes.

Mortality is increased among patients with peripheral vascular disease and diabetes, in particular if foot ulcerations, infection or gangrene occur. There is limited information on whether the presence of heart, stroke and vascular disease promotes diabetes in some way.

High blood pressure, high cholesterol and obesity are often present along with diabetes. As well as all being independent cardiovascular risk factors, when they are in combination with glucose intolerance (a feature of diabetes) and other risk factors such as physical inactivity and smoking, these factors present a greater risk for heart, stroke and vascular disease.

Evidence is accumulating that high cholesterol and glucose intolerance, which often occur together, may have a common aetiological factor. Despite these similarities, trends in cardiovascular mortality and diabetes incidence and mortality are moving in opposite directions.

While the ageing of the population following reductions in cardiovascular mortality may have contributed to these contrasting trends, the role of other factors also needs to be clearly understood if common risk factor prevention strategies are to be considered (from Commonwealth Department of Health & Ageing and Australian Institute of Health and Welfare (1999) National Health Priority Areas Report: Cardiovascular Health).

In settings such as general practice where the monitoring of a person's health is ongoing and where diabetes status can change over time, the service contact date should be recorded.

DSS - Diabetes (clinical):

Uncontrolled diabetes leads to a variety of complications, often resulting in limitation of activity, disability, illness and premature mortality. Therefore ongoing assessment is required to identify people at risk of developing complications so that early preventive strategies can be applied. Although there is no cure for diabetes, with modern treatment most people can lead a full and active life and avoid long-term complications.

Aetiological classifications contained in the scientific paper 'Definition, Diagnosis and Classification of Diabetes Mellitus and its Complications Part 1: Diagnosis and Classifications of Diabetes Mellitus Provisional Report of a WHO Consultation' (Alberti & Zimmet 1998).

Diabetes therapy type

Identifying and Definitional Attributes

Knowledgebase ID:	000668	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	The type of diabetes therapy the person is currently receiving.		
Context:	Public health, health care and clinical setting: Its main use is to enable categorisation of management regimes against best practice for diabetes.		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	NN
Minimum size:	2
Maximum size:	2
Data domain:	<ul style="list-style-type: none"> 01 Diet and exercise only 02 Oral hypoglycaemic – sulphonylurea only 03 Oral hypoglycaemic – biguanide (e.g. metformin) only 04 Oral hypoglycaemic – alpha-glucosidase inhibitor only 05 Oral hypoglycaemic – thiazolidinedione only 06 Oral hypoglycaemic – meglitinide only 07 Oral hypoglycaemic – combination (e.g. biguanide and sulphonylurea) 08 Oral hypoglycaemic – other 09 Insulin only 10 Insulin plus oral hypoglycaemic 98 Nil – not currently receiving diabetes treatment 99 Not stated/inadequately described
Guide for use:	<p>Code 01 includes the options of generalised prescribed diet; avoid added sugar/simple carbohydrates; low joule diet; portion exchange diet and uses glycaemic index and a recommendation for increased exercise.</p> <p>Code 98 no current diet, tablets or insulin therapy(ies)</p> <p>Code 99 missing information</p>
Verification rules:	
Collection methods:	To be collected at the commencement of treatment and at each review.
Related metadata:	<ul style="list-style-type: none"> relates to the data element Diabetes status vers 1 relates to the data element Renal disease therapy vers 1 is used in conjunction with Service contact date vers 1 relates to the data element Vascular history vers 1 relates to the data element Year insulin started vers 1

Administrative Attributes

Source document:

Source organisation: National Diabetes Data Working Group
CV-Data Working Group

Information model link:

NHIM Physical wellbeing

Data Set Specifications:

	<i>Start date</i>	<i>End date</i>
DSS - Cardiovascular disease (clinical)	01/01/2003	
DSS - Diabetes (clinical)	01/01/2003	

Comments:

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

DSS - Diabetes (clinical):

The objectives and priorities of treatment must be tailored to the individual considering age, sex, weight and individual health status.

An individual management plan for each patient should include the following:

- establishment of targets of treatment
- healthy eating plan
- education in self-monitoring
- adjustment of treatment and in approaches to coping with emergencies
- exercise program
- risk factor reduction, e.g. smoking cessation
- use of oral hypoglycaemic agents, if required
- use of insulin, if required
- screening for and treatment of complications of diabetes.

In addition to glycaemic control, management of diabetes of either type requires close attention to other risk factors for the development of complications, and the impact of lifestyle changes on blood glucose levels should be monitored. In patients with Type 2 diabetes, an increase in physical activity is essential in management of lipids and glucose level. Increased physical activity has been recognised as perhaps the most feasible way of modifying glucose intolerance, a risk factor for developing diabetes and macrovascular disease (Guest & O'Dea 1992).

References:

Berkow R, editor. The Merck Manual. 16th ed. Rahway (New Jersey, USA): Merck Research Laboratories; 1992.

Diagnosis

Identifying and Definitional Attributes

Knowledgebase ID:	000398	Version No:	1
Metadata type:	Data Element Concept		
Admin. status:	Current		
	01/07/98		
Definition:	A diagnosis is the decision reached, after assessment, of the nature and identity of the disease or condition of a patient.		
Context:	Health services: Diagnostic information provides the basis for analysis of health service usage, epidemiological studies and monitoring of specific disease entities.		

Relational and Representational Attributes

Datatype:	
Representational form:	
Representational layout:	
Minimum size:	
Maximum size:	
Data domain:	
Guide for use:	
Verification rules:	
Collection methods:	
Related metadata:	<ul style="list-style-type: none"> relates to the data element Additional diagnosis vers 4 relates to the data element Complication of labour and delivery vers 2 relates to the data element Complications of pregnancy vers 2 relates to the data element Congenital malformations vers 2 relates to the data element External cause - admitted patient vers 4 relates to the data element Maternal medical conditions vers 2 relates to the data element Neonatal morbidity vers 2 relates to the data element Postpartum complication vers 2 relates to the data element Principal diagnosis vers 3

Administrative Attributes

Source document:			
Source organisation:	National Health Data Committee		
Information model link:	NHIM Physical wellbeing		
Data Set Specifications:		Start date	End date
Comments:	<p>Classification systems which enable the allocation of a code to the diagnostic information:</p> <ul style="list-style-type: none"> International Classification of Diseases - Tenth Revision - Australian Modification (ICD-10-AM) British Paediatric Association Classification of Diseases North America Nursing Diagnosis Association International Classification of Primary Care International Classification of Impairments, Disabilities and Handicaps International Classification of Functioning 		

Diagnosis onset type

Identifying and Definitional Attributes

Knowledgebase ID:	000773	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/02		
Definition:	A qualifier for each coded diagnosis to indicate the onset and/or significance of the diagnosis to the episode of care		
Context:	Health services: Improved analysis of diagnostic information, especially in relation to patient safety and adverse event monitoring		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	N
Minimum size:	1
Maximum size:	1

Data domain:	1	Primary condition
	2	Post-admit condition
	9	Unknown or uncertain

Guide for use:	Assign the relevant diagnosis type flag to all of the ICD-10-AM disease codes recorded in the hospital morbidity system. Specific guidelines for correct assignment of diagnosis flag type are in ICD-10-AM Australian Coding Standards, Third Edition 1 July 2002.
	The following rules only apply to: <ul style="list-style-type: none"> - diagnoses which meet the criteria in the Australian Coding Standards (ACS) 0001 Principal diagnosis and ACS 0002 Additional diagnoses or a specialty standard which requires the use of an additional code(s). - hospital morbidity data - 'episode of care' refers to hospital or day procedure episodes of care
	1 Primary condition <ul style="list-style-type: none"> - a condition present on admission such as the presenting problem, a comorbidity, chronic disease or disease status. In the case of neonates, the condition(s) present at birth. - a previously existing condition not diagnosed until the current episode of care - in delivered obstetric cases, all conditions which arise from the beginning of labour to the end of second stage
	2 Post-admit condition <ul style="list-style-type: none"> - a condition which arises during the current episode of care and would not have been present on admission
	9 Unknown or uncertain <ul style="list-style-type: none"> - a condition where the documentation does not support assignment to 1 or 2

Explanatory Notes:

The flag on external cause, place of occurrence and activity codes should match that of the corresponding injury or disease code.

The flag on morphology codes should match that on the corresponding neoplasm code.

Conditions meeting the criteria of principal diagnosis may, in some cases, have a flag of 2.

Verification rules:**Collection methods:**

A diagnosis onset type should be recorded and coded upon completion of an episode of admitted patient care.

Related metadata:

relates to the data element Activity when injured vers 2

relates to the data element Additional diagnosis vers 4

relates to the data element External cause – admitted patient vers 4

relates to the data element Place of occurrence of external cause of injury vers 5

relates to the data element Principal diagnosis vers 3

Administrative Attributes**Source document:**

Source organisation: National Centre for Classification in Health

Information model link:

NHIM Request for/entry into service event

Data Set Specifications:**Start date****End date****Comments:**

Diagnosis related group

Identifying and Definitional Attributes

Knowledgebase ID:	000042	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/93	
Definition:	A patient classification scheme which provides a means of relating the number and types of patients treated in a hospital to the resources required by the hospital.	

Context: The development of Australian refined diagnosis related groups has created a descriptive framework for studying hospitalisation. Diagnosis related groups provide a summary of the varied reasons for hospitalisation and the complexity of cases a hospital treats. Moreover, as a framework for describing the products of a hospital (that is, patients receiving services), they allow meaningful comparisons of hospitals' efficiency and effectiveness under alternative systems of health care provision.

Relational and Representational Attributes

Datatype:	Alphanumeric
Representational form:	Code
Representational layout:	ANNA
Minimum size:	4
Maximum size:	4

Data domain: Australian refined diagnosis related groups, Commonwealth of Australia. Version effective from 1 July each year.

Guide for use:

Verification rules:

Collection methods:

Related metadata:

- is derived from Additional diagnosis vers 4
- is derived from Admission date vers 4
- is derived from Date of birth vers 4
- is derived from Infant weight, neonate, stillborn vers 3
- is derived from Intended length of hospital stay vers 2
- is derived from Mode of separation vers 3
- is derived from Principal diagnosis vers 3
- is derived from Procedure vers 5
- is derived from Separation date vers 5
- is derived from Sex vers 3

Administrative Attributes

Source document:

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

Information model link:

NHIM Physical wellbeing

Data Set Specifications:

NMDS - Admitted patient care

Start date**End date**

01/07/1993

NMDS - Admitted patient mental health care

01/07/1997

Comments:

The Australian refined diagnosis related group is derived from a range of data collected on admitted patients, including diagnosis and procedure information, classified using ICD-10-AM. The data elements required are described in the related metadata section.

Division of General Practice number

Identifying and Definitional Attributes

Knowledgebase ID:	000669	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	The Division of General Practice number as designated by the Commonwealth Government of Australia. Each separately administered Division of General Practice has a unique identifying number.		
Context:	Public health and health care: To facilitate outcomes focused collection, linkage, pooling, analysis, reporting and feedback of aggregated data, which could potentially be linked to other health initiatives.		

Relational and Representational Attributes

Datatype:	Numeric		
Representational form:	Code		
Representational layout:	NNN		
Minimum size:	3		
Maximum size:	3		
Data domain:	Codes defined in the Commonwealth Department of Health and Ageing: General Practice in Australia: 2000. First Edition May 2000.		
Guide for use:	Divisions of General Practice are geographically based networks of general practitioners. In geographical terms, each Division of General Practice can be described by the postcodes that fall within its jurisdiction.		
Verification rules:			
Collection methods:			
Related metadata:	relates to the data element Person identifier vers 1		

Administrative Attributes

Source document:	Commonwealth Department of Health and Ageing: General Practice in Australia: 2000. First Edition May 2000.		
Source organisation:	CV-Data Working Group		
Information model link:	NHIM Service provider role		
Data Set Specifications:		Start date	End date
DSS - Cardiovascular disease (clinical)		01/01/2003	

Comments:

Domestic services

Identifying and Definitional Attributes

Knowledgebase ID:	000241	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/89		
Definition:	The costs of all domestic services including electricity, other fuel and power, domestic services for staff, accommodation and kitchen expenses but not including salaries and wages, food costs or equipment replacement and repair costs. Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers.		
Context:	Health expenditure: This is a significant element of non-salary recurrent expenditure for most establishments within the data set and is thus required for any health expenditure analysis at the national level.		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Currency
Representational layout:	\$999,999,999
Minimum size:	2
Maximum size:	12
Data domain:	Australian dollars. Rounded to nearest whole dollar.
Guide for use:	Record values up to hundreds of millions of dollars.
Verification rules:	
Collection methods:	
Related metadata:	relates to the data element Establishment type vers 1

Administrative Attributes

Source document:			
Source organisation:	National Health Data Committee		
Information model link:	NHIM Recurrent expenditure		
Data Set Specifications:		Start date	End date
	NMDS - Public hospital establishments	01/07/1989	

Comments:	The possibility of separating fuel, light and power from domestic services which would bring the overall non-salary recurrent expenditure categories closer to the old Hospitals and Allied Services Advisory Council categories was briefly considered by the Resources Working Party but members did not hold strong views in this area.
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Drug supplies

Identifying and Definitional Attributes

Knowledgebase ID:	000238	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/89		
Definition:	The cost of all drugs including the cost of containers. Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers.		
Context:	Health expenditure: This is a significant element of non-salary recurrent expenditure and also national level data on drug expenditure in hospitals is of considerable interest in its own right to a wide range of persons and organisations.		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Currency
Representational layout:	\$999,999,999
Minimum size:	2
Maximum size:	12
Data domain:	Australian dollars. Rounded to nearest whole dollar.
Guide for use:	Record values up to hundreds of millions of dollars.
Verification rules:	
Collection methods:	
Related metadata:	relates to the data element Establishment type vers 1

Administrative Attributes

Source document:			
Source organisation:	National Health Data Committee		
Information model link:	NHIM Recurrent expenditure		
Data Set Specifications:		Start date	End date
	NMDS - Public hospital establishments	01/07/1989	
Comments:			

Dyslipidaemia – treatment

Identifying and Definitional Attributes

Knowledgebase ID:	000814	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	Whether an individual is currently treated for dyslipidaemia (abnormal lipid levels) using anti-lipid medication.		
Context:	Public health, health care and clinical settings.		

Relational and Representational Attributes

Datatype:	Numeric						
Representational form:	Code						
Representational layout:	N						
Minimum size:	1						
Maximum size:	1						
Data domain:	<table> <tr> <td>1</td> <td>Yes – currently treated for dyslipidaemia using anti-lipid medication</td> </tr> <tr> <td>2</td> <td>No – not currently treated for dyslipidaemia using anti-lipid medication</td> </tr> <tr> <td>9</td> <td>Not stated/inadequately described</td> </tr> </table>	1	Yes – currently treated for dyslipidaemia using anti-lipid medication	2	No – not currently treated for dyslipidaemia using anti-lipid medication	9	Not stated/inadequately described
1	Yes – currently treated for dyslipidaemia using anti-lipid medication						
2	No – not currently treated for dyslipidaemia using anti-lipid medication						
9	Not stated/inadequately described						

Guide for use: Record as code 1 if on drug treatment for dyslipidaemia.

Verification rules:

Collection methods: Ask the individual if he/she is currently treated with anti-lipid medication. Alternatively obtain the relevant information from appropriate documentation.

Related metadata:

- relates to the data element Cholesterol-HDL – measured vers 1
- relates to the data element Cholesterol-total – measured vers 1
- relates to the data element Fasting status vers 1
- relates to the data element Triglycerides – measured vers 1

Administrative Attributes

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

Source organisation: National Diabetes Data Working Group

Information model link:

NHIM Request for/entry into service event

Data Set Specifications:	Start date	End date
DSS – Diabetes (clinical)	01/01/2003	

Comments: Dyslipidaemia is an excessive accumulation of one or more of the major lipids transported in plasma. Plasma lipid levels may be reduced by a variety of

agents having different mechanisms of action. They also have different effects on the plasma lipid profile.

Dyslipidaemia is associated with many health problems including diabetes and hypertension. It is often related to overweight and obesity. Usually caused by inappropriate diet and sedentary lifestyle, dyslipidaemia has been reaching epidemic proportions. Active lifestyle and low calorie diets are the best way of prevention, however sometimes for the treatment of dyslipidaemia the use of pharmacotherapy is required. Abnormal levels of blood lipids are associated with increased risk of developing coronary heart disease especially in diabetic patients.

The risk of coronary and other macrovascular disorders is 2-5 times higher in people with diabetes than in non-diabetic subjects and increases in parallel with the degree of dyslipidaemia. Diabetes mellitus greatly modifies the significance of lipoprotein levels, particularly when associated with smoking, hypertension and family history of cardiovascular disease. Poor metabolic control of diabetes seems to have impact on abnormal lipoprotein level.

Primary dyslipidaemia, due to genetic and environmental (especially dietary) factors, is diagnosed if secondary causes have been excluded (hypothyroidism, nephrotic syndrome, cholestasis, anorexia nervosa, diabetes mellitus Type 2, renal impairment).

Elective care

Identifying and Definitional Attributes

<i>Knowledgebase ID:</i>	000348	<i>Version No:</i>	1
<i>Metadata type:</i>	Data Element Concept		
<i>Admin. status:</i>	Current		
	01/07/95		
<i>Definition:</i>	Care that, in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least 24 hours.		
<i>Context:</i>	Admitted patient care.		

Relational and Representational Attributes

<i>Datatype:</i>	
<i>Representational form:</i>	
<i>Representational layout:</i>	
<i>Minimum size:</i>	
<i>Maximum size:</i>	
<i>Data domain:</i>	
<i>Guide for use:</i>	
<i>Verification rules:</i>	
<i>Collection methods:</i>	
<i>Related metadata:</i>	relates to the data element Waiting list category vers 3

Administrative Attributes

<i>Source document:</i>	
<i>Source organization:</i>	Hospital Access Program Waiting List Working Group National Health Data Committee
<i>Information model link:</i>	NHIM Service provision event
<i>Data Set Specifications:</i>	<i>Start date</i> <i>End date</i>

Comments:

Elective surgery

Identifying and Definitional Attributes

<i>Knowledgebase ID:</i>	000046	<i>Version No:</i>	1
<i>Metadata type:</i>	Data Element Concept		
<i>Admin. status:</i>	Current		
	01/07/95		
<i>Definition:</i>	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.		
<i>Context:</i>	Admitted patient care.		

Relational and Representational Attributes

<i>Datatype:</i>	
<i>Representational form:</i>	
<i>Representational layout:</i>	
<i>Minimum size:</i>	
<i>Maximum size:</i>	
<i>Data domain:</i>	
<i>Guide for use:</i>	
<i>Verification rules:</i>	
<i>Collection methods:</i>	
<i>Related metadata:</i>	relates to the data element Waiting list category vers 3

Administrative Attributes

<i>Source document:</i>	
<i>Source organisation:</i>	Hospital Access Program Waiting List Working Group National Health Data Committee
<i>Information model link:</i>	NHIM Service provision event
<i>Data Set Specifications:</i>	<i>Start date</i> <i>End date</i>

Comments:

Emergency department – public hospital

Identifying and Definitional Attributes

Knowledgebase ID:	000815	Version No:	1
Metadata type:	Data Element Concept		
Admin. status:	Current		
	01/07/03		
Definition:	<p>The dedicated area in a public hospital that is organised and administered to provide emergency care to those in the community who perceive the need for or are in need of acute or urgent care.</p> <p>The emergency department must be part of a hospital and be licensed or otherwise recognised as an emergency department by the appropriate State or Territory authority.</p> <p>An emergency department provides triage, assessment, care and/or treatment for patients suffering from medical condition(s) and/or injury.</p>		
Context:	Emergency department care.		

Relational and Representational Attributes

Datatype:	
Representational form:	
Representational layout:	
Minimum size:	
Maximum size:	
Data domain:	
Guide for use:	
Verification rules:	
Collection methods:	
Related metadata:	relates to the data element concept Non-admitted patient emergency department service episode vers 1

Administrative Attributes

Source document:			
Source organisation:	National reference group for non-admitted patient data development, 2001–02		
Information model link:	NHIM Service delivery setting		
Data Set Specifications:		Start date	End date

Comments:	<p>This data element concept has been defined to support the NMDS – Non-admitted patient emergency department care. It is not intended as a definitive statement of the role or purpose of an emergency department.</p> <p>The national definition of an emergency department and the care that is provided in an emergency department is characterised by jurisdictional and local differences. For example, there is no national agreement on the identification and classification of emergency department-related settings such as observation units, short-stays units, or the use of ‘admitted patient beds’ located in an emergency department setting.</p> <p>Emergency department is therefore defined as a concept, and not necessarily as a physical premises, setting or site.</p>
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Emergency department arrival mode – transport

Identifying and Definitional Attributes

Knowledgebase ID:	000816	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/03		
Definition:	The mode of transport by which the person arrives at the emergency department.		
Context:	Emergency department care.		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	N
Minimum size:	1
Maximum size:	1

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

Guide for use: Code 8 (Other) includes patients who walked in, came by private transport, public transport, community transport, or taxi.

Verification rules:

Collection methods:

Related metadata:

Administrative Attributes

Source document:

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

Information model link:

NHIM Request for/entry into service event

Data Set Specifications:	Start date	End date
NMDS - Non-admitted patient emergency department care	01/07/2003	

Comments:

Emergency department departure status

Identifying and Definitional Attributes

Knowledgebase ID:	000359	Version No:	2
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/03		
Definition:	The status of the patient at the end of the non-admitted patient emergency department service episode		
Context:	Non-admitted patient emergency department care.		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	N
Minimum size:	1
Maximum size:	1
Data domain:	<ol style="list-style-type: none"> 1 Admitted to this hospital (including to units or beds within the emergency department) 2 Non-admitted patient emergency department service episode completed - departed without being admitted or referred to another hospital 3 Referred to another hospital for admission 4 Did not wait to be attended by a health care professional 5 Left at own risk after being attended by a health care professional but before the non-admitted patient emergency department service episode was completed 6 Died in emergency department as a non-admitted patient 7 Dead on arrival, not treated in emergency department

Guide for use: A non-admitted patient emergency department service episode ends when either the patient is admitted or, if the patient is not to be admitted, when the patient is recorded as ready to leave the emergency department or when they are recorded as having left at their own risk.

Code 2 includes patients who departed under their own care, under police custody and under the care of a residential aged care facility or other carer. Code 2 excludes those who died in the emergency department, which should be coded to Code 6.

Verification rules:

Collection methods:

Related metadata:

- relates to the data element Date of commencement of service event vers 2
- relates to the data element Date patient presents vers 2
- supersedes previous data element Departure status vers 1
- relates to the data element concept Emergency department - public hospital vers 1
- relates to the data element Emergency department waiting time to admission vers 1

relates to the data element Emergency department waiting time to service delivery vers 2

relates to the data element concept Patient presentation at emergency department vers 1

relates to the data element Time of commencement of service event vers 2

relates to the data element Time patient presents vers 2

relates to the data element Type of visit to emergency department vers 2

Administrative Attributes

Source document:

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

Information model link:

NHIM Exit/leave from service event

<i>Data Set Specifications:</i>	<i>Start date</i>	<i>End date</i>
NMDS - Emergency department waiting times	01/07/2003	
NMDS - Non-admitted patient emergency department care	01/07/2003	

Comments:

Emergency department waiting time to admission

Identifying and Definitional Attributes

Knowledgebase ID: 000397 **Version No:** 1

Metadata type: Derived Data Element

Admin. status: Current
01/07/98

Definition: The time elapsed for each patient from presentation to the emergency department to admission to hospital.

Context: Emergency department care:
This is a critical waiting times data item. This item is used to examine the length of waiting time, for performance indicators and benchmarking. Information based on this data item will have many uses including to assist in the planning and management of hospitals and in health care research.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Time

Representational layout: HHMM

Minimum size: 4

Maximum size: 4

Data domain: Count in numbers of hours and minutes

Guide for use: Calculated from admission date and time minus date and time patient presents for those emergency department patients who are admitted.

Verification rules:

Collection methods: To be collected on patients presenting to emergency department for unplanned care in public hospitals with emergency department and private hospitals providing contracted services for the public sector.

Related metadata:
is calculated using Admission date vers 4
is calculated using Admission time vers 2
is calculated using Date patient presents vers 2
is calculated using Emergency department departure status vers 2
relates to the data element concept Patient presentation at emergency department vers 1
is calculated using Time patient presents vers 2

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Performance indicator

Data Set Specifications: **Start date** **End date**

Comments:

Emergency department waiting time to service delivery

Identifying and Definitional Attributes

Knowledgebase ID:	000347	Version No:	2
Metadata type:	Derived Data Element		
Admin. status:	Current		
	01/01/00		
Definition:	The time elapsed for each patient from presentation in the emergency department to commencement of service by a treating medical officer or nurse.		
Context:	Non-admitted patient emergency department care.		

Relational and Representational Attributes

Datatype:	Numeric		
Representational form:			
Representational layout:	MMMMM		
Minimum size:	5		
Maximum size:	5		
Data domain:	Time in minutes		
Guide for use:	Calculated from the date and time of service event minus date and time patient presents. Although triage category 1 is measured in seconds, it is recognised that the data will not be collected with this precision.		
Verification rules:			
Collection methods:			
Related metadata:	<p>supersedes previous data element Emergency department waiting time to service delivery vers 1</p> <p>relates to the data element concept Emergency department - public hospital vers 1</p> <p>is calculated using Date of commencement of service event vers 2</p> <p>is calculated using Date patient presents vers 2</p> <p>is calculated using Time of commencement of service event vers 2</p> <p>is calculated using Time patient presents vers 2</p>		

Administrative Attributes

Source document:			
Source organisation:	National reference group for non-admitted patient data development, 2001-02		
Information model link:	NHIM Performance indicator		
Data Set Specifications:	Start date	End date	
NMDS - Emergency department waiting times	01/07/2000		
NMDS - Non-admitted patient emergency department care	01/07/2003		
Comments:	It is recognised that at times of extreme urgency or multiple synchronous presentations, or if no medical officer is on duty in the emergency department, this service may be provided by a nurse.		

Employment status – acute hospital and private psychiatric hospital admissions

Identifying and Definitional Attributes

Knowledgebase ID:	000395	Version No:	2
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/97		
Definition:	Self-reported employment status of a person, immediately prior to admission to an acute or private psychiatric hospital.		

Context: The Australian Health Ministers' Advisory Council Health Targets and Implementation Committee (1988) identified socioeconomic status as the most important factor explaining health differentials in the Australian population. The committee recommended that national health statistics routinely identify the various groups of concern. This requires routine recording in all collections of indicators of socioeconomic status. In order of priority, these would be employment status, income, occupation and education.

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	N
Minimum size:	1
Maximum size:	1
Data domain:	1 Unemployed/pensioner 2 Other

Guide for use:

Verification rules:

Collection methods: In practice, this data item and current or last occupation could probably be collected with a single question, as is done in Western Australia:

Occupation?

For example:

- housewife or home duties
- pensioner miner
- tree feller
- retired electrician
- unemployed trades assistant
- child
- student
- accountant

However, for national reporting purposes it is preferable to distinguish these two data items logically.

Related metadata: supersedes previous data element Employment status vers 1
 relates to the data element Employment status – public psychiatric hospital admissions vers 2

Administrative Attributes

Source document:

Source organisation: National minimum data set working parties

Information model link:

NHIM Labour characteristic

Data Set Specifications:	Start date	End date
NMDS – Admitted patient mental health care	01/07/1997	

Comments:

Employment status – public psychiatric hospital admissions

Identifying and Definitional Attributes

Knowledgebase ID:	000317	Version No:	2
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/97		
Definition:	Self-reported employment status of a person, immediately prior to admission to a public psychiatric hospital.		
Context:	The Australian Health Ministers' Advisory Council Health Targets and Implementation Committee (1988) identified socioeconomic status as the most important factor explaining health differentials in the Australian population. The committee recommended that national health statistics routinely identify the various groups of concern. This requires routine recording in all collections of indicators of socioeconomic status. In order of priority, these would be employment status, income, occupation and education.		

Relational and Representational Attributes

Datatype:	Numeric												
Representational form:	Code												
Representational layout:	N												
Minimum size:	1												
Maximum size:	1												
Data domain:	<table> <tr><td>1</td><td>Child not at school</td></tr> <tr><td>2</td><td>Student</td></tr> <tr><td>3</td><td>Employed</td></tr> <tr><td>4</td><td>Unemployed</td></tr> <tr><td>5</td><td>Home duties</td></tr> <tr><td>6</td><td>Other</td></tr> </table>	1	Child not at school	2	Student	3	Employed	4	Unemployed	5	Home duties	6	Other
1	Child not at school												
2	Student												
3	Employed												
4	Unemployed												
5	Home duties												
6	Other												

Guide for use:

Verification rules:

Collection methods: In practice, this data item and current or last occupation could probably be collected with a single question, as is done in Western Australia:

What is your/the person's Occupation?

For example:

- housewife or home duties
- pensioner miner
- tree feller
- retired electrician
- unemployed trades assistant
- child
- student
- accountant.

However, for national reporting purposes it is preferable to distinguish these two data items logically.

Related metadata: supersedes previous data element Employment status vers 1
 relates to the data element Employment status – acute hospital and private
 psychiatric hospital admissions vers 2

Administrative Attributes

Source document:

Source organisation: National minimum data set working parties

Information model link:

NHIM Labour characteristic

Data Set Specifications:	Start date	End date
NMDS – Admitted patient mental health care	01/07/1997	

Comments:

Episode of care

Identifying and Definitional Attributes

Knowledgebase ID:	000445	Version No:	1
Metadata type:	Data Element Concept		
Admin. status:	Current		
	01/07/00		
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

Datatype:	
Representational form:	
Representational layout:	
Minimum size:	
Maximum size:	
Data domain:	
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).
Verification rules:	
Collection methods:	
Related metadata:	<ul style="list-style-type: none"> relates to the data element concept Admission vers 3 relates to the data element concept Admission date vers 4 relates to the data element concept Admitted patient vers 3 relates to the data element Care type vers 4 relates to the data element concept Separation vers 3 relates to the data element Separation date vers 5

Administrative Attributes

Source document:			
Source organisation:	National Health Data Committee		
Information model link:	NHIM Service provision event		
Data Set Specifications:		Start date	End date
Comments:			

Erectile dysfunction

Identifying and Definitional Attributes

Knowledgebase ID:	000817	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	Whether a male individual has a history of erection failure or has received treatment to achieve erection sufficient for penetration in the last 12 months and prior.		
Context:	Public health, health care and clinical settings.		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	N
Minimum size:	1
Maximum size:	1

Data domain:	1	Erectile dysfunction – developed in the last 12 months
	2	Erectile dysfunction – developed prior to the last 12 months
	3	No erectile dysfunction
	9	Not stated/inadequately described

Guide for use: Record for male patients only.

Verification rules:

Collection methods: Ask the individual if he has a history of treatment or failure to achieve or maintain erection sufficient for penetration. Determine whether this developed within or prior to the last 12 months.

Related metadata: relates to the data element Peripheral neuropathy – status vers 1
relates to the data element Peripheral vascular disease in feet – status vers 1

Administrative Attributes

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

Source organisation: National Diabetes Data Working Group

Information model link:

NHIM Physical wellbeing

Data Set Specifications:	Start date	End date
DSS – Diabetes (clinical)	01/01/2003	

Comments: Erectile dysfunction or impotence is defined as inability to achieve or maintain an erection of sufficient rigidity to perform sexual intercourse successfully. It may be due to psychological causes, macrovascular disease or pelvic autonomic neuropathy. An organic cause is more likely in the presence of other macro or micro vascular complications.
Erectile problems occur in up to 50% of men with diabetes who are over 40 years old.

Establishment identifier

Identifying and Definitional Attributes

Knowledgebase ID:	000050	Version No: 4
Metadata type:	Derived Data Element	
Admin. status:	Current	
	01/07/03	
Definition:	Identifier for the establishment in which episode or event occurred. Each separately administered health care establishment to have a unique identifier at the national level.	

Context:

Relational and Representational Attributes

Datatype:	Alphanumeric
Representational form:	Code
Representational layout:	NNA(N)NNNNN
Minimum size:	9
Maximum size:	9
Data domain:	Concatenation of: State/Territory identifier (character position 1) Establishment sector (character position 2) Region code (character positions 3-4) Establishment number (character positions 5-9)

Guide for use:

Verification rules:

Collection methods:

Related metadata:	supersedes previous data element Establishment identifier vers 3
	is composed of Establishment number vers 4
	is composed of Establishment sector vers 3
	relates to the data element Person identifier vers 1
	relates to the data element Person identifier type – health care vers 1
	is composed of Region code vers 2
	is composed of State/Territory identifier vers 3

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Organisation characteristic

Data Set Specifications:	Start date	End date
NMDS - Admitted patient care	01/07/2003	
NMDS - Admitted patient mental health care	01/07/2003	
NMDS - Admitted patient palliative care	01/07/2003	
NMDS - Alcohol and other drug treatment services	01/07/2003	
NMDS - Community mental health care	01/07/2003	
NMDS - Community mental health establishments	01/07/2003	
NMDS - Elective surgery waiting times	01/07/2003	
NMDS - Emergency department waiting times	01/07/2003	
NMDS - Non-admitted patient emergency department care	01/07/2003	
NMDS - Perinatal	01/07/2003	
NMDS - Public hospital establishments	01/07/2003	
DSS - Health care client identification	01/01/2003	

Comments:

Establishment identifier should be able to distinguish between all health care establishments nationally.

NMDS - Admitted patient care:

A residential establishment is considered to be separately administered if managed as an independent institution for which there are financial, budgetary and activity statistics. For example, if establishment-level data for components of an area health service are not available separately at a central authority, this is not grounds for treating such components as a single establishment unless such data are not available at any level in the health care system.

This item is now being used to identify hospital contracted care. The use of this item will lead to reduced duplication in reporting patient activity and will enable linkage of services to one episode of care.

Establishment number

Identifying and Definitional Attributes

Knowledgebase ID:	000377	Version No:	4
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/03		
Definition:	An identifier for an establishment, unique within the State or Territory.		
Context:	All health services.		

Relational and Representational Attributes

Datatype:	Numeric		
Representational form:	Identification number		
Representational layout:	NNNNN		
Minimum size:	5		
Maximum size:	5		
Data domain:	Valid establishment number		
Guide for use:			
Verification rules:			
Collection methods:			
Related metadata:	is a composite part of Establishment identifier vers 4 supersedes previous data element Establishment number vers 3		

Administrative Attributes

Source document:			
Source organisation:			
Information model link:	NHIM Organisation characteristic		
Data Set Specifications:		Start date	End date
DSS - Health care client identification		01/01/2003	

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 NMDS - Emergency department waiting times. Establishment number should be a unique code for the health care establishment used in that State/Territory or uniquely at a national level.
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Establishment sector

Identifying and Definitional Attributes

Knowledgebase ID:	000379	Version No:	3
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/01		
Definition:	A section of the health care industry with which a health care establishment can identify.		

Context:

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	N
Minimum size:	1
Maximum size:	1

Data domain:	1	Public
	2	Private

Guide for use:

Verification rules:

Collection methods:

Related metadata: is a composite part of Establishment identifier vers 4
supersedes previous data element Establishment sector vers 2

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Organisational setting

Data Set Specifications:	Start date	End date
DSS - Health care client identification	01/01/2003	

Comments:

Establishment type

Identifying and Definitional Attributes

Knowledgebase ID: 000327 **Version No:** 1

Metadata type: Data Element

Admin. status: Current
01/07/89

Definition: Type of establishment (defined in terms of legislative approval, service provided and patients treated) for each separately administered establishment. Residential establishments are considered to be separately administered if managed as an independent unit in terms of financial, budgetary and activity statistics. The situation where establishment-level data, say for components of an area health service, were not available separately at a central authority was not grounds for treating such a group of establishments as a single establishment unless such data were not available at any level in the health care system.

Non-residential health services are classified in terms of separately administered organisations rather than in terms of the number of sites at which care is delivered. Thus, domiciliary nursing services would be counted in terms of the number of administered entities employing nursing staff rather than in terms of the number of clinic locations used by the staff.

Establishments can cater for a number of activities and in some cases separate staff and financial details are not available for each activity. In the cases it is necessary to classify the establishment according to its predominant residential activity (measured by costs) and to allocate all the staff and finances to that activity. Where non-residential services only are provided at one establishment, that establishment is classified according to the predominant non-residential activity (in terms of costs).

Context: Health services:
Type of establishment is required in order to aggregate establishment-level data into meaningful summary categories (e.g. public hospitals, residential aged care services) for reporting and analysis.

Relational and Representational Attributes

Datatype: Alphanumeric

Representational form: Code

Representational layout: AN.N.N

Minimum size: 2

Maximum size: 6

Data domain:

- N7.1 Public day centre/hospital
- N7.2 Public freestanding day surgery centre
- N7.3 Private day centre/hospital
- N7.4 Private freestanding day surgery centre
- N8.1.1 Public community health centre
- N8.1.2 Private (non-profit) community health centre
- N8.2.1 Public domiciliary nursing service
- N8.2.2 Private (non-profit) domiciliary nursing service

N8.2.3	Private (profit) domiciliary nursing service
R1.1	Public acute care hospital
R1.2	Private acute care hospital
R1.3.1	Veterans' Affairs hospital
R1.3.2	Defence force hospital
R1.3.3	Other Commonwealth hospital
R2.1	Public psychiatric hospital
R2.2	Private psychiatric hospital
R3.1	Private charitable nursing home for the aged
R3.2	Private profit nursing home for the aged
R3.3	Government nursing home for the aged
R3.4	Private charitable nursing home for young disabled
R3.5	Private profit nursing home for young disabled
R3.6	Government nursing home for young disabled
R4.1	Public alcohol and drug treatment centre
R4.2	Private alcohol and drug treatment centre
R5.1	Charitable hostels for the aged
R5.2	State government hostel for the aged
R5.3	Local government hostel for the aged
R5.4	Other charitable hostel
R5.5	Other State government hostel
R5.6	Other Local government hostel
R6.1	Public hospice
R6.2	Private hospice

Guide for use:

Establishments are classified into 10 major types subdivided into major groups:

- residential establishments (R)
- non-residential establishments (N)

R1 Acute care hospitals:

Establishments which provide at least minimal medical, surgical or obstetric services for inpatient treatment and/or care, and which provide round-the-clock comprehensive qualified nursing service as well as other necessary professional services. They must be licensed by the State health department, or controlled by government departments. Most of the patients have acute conditions or temporary ailments and the average stay per admission is relatively short.

Hospitals specialising in dental, ophthalmic aids and other specialised medical or surgical care are included in this category. Hospices (establishments providing palliative care to terminally ill patients) that are freestanding and do not provide any other form of acute care are classified to R6.

R2 Psychiatric hospitals:

Establishments devoted primarily to the treatment and care of inpatients with psychiatric, mental, or behavioural disorders. Private hospitals formerly approved by the Commonwealth Department of Health under the Health Insurance Act 1973 (Commonwealth) (now licensed/approved by each State health authority), catering primarily for patients with psychiatric or behavioural disorders are included in this category.

Centres for the non-acute treatment of drug dependence, developmental and intellectual disability are not included here (see below). This code also excludes institutions mainly providing living quarters or day care.

R3 Nursing homes:

Establishments which provide long-term care involving regular basic nursing care to chronically ill, frail, disabled or convalescent persons or senile inpatients. They must be approved by the Commonwealth Department of Health and Family Services and/or licensed by the State, or controlled by government departments.

Private profit nursing homes are operated by private profit-making individuals or bodies.

Private charitable nursing homes are participating nursing homes operated by religious and charitable organisations.

Government nursing homes are nursing homes either operated by or on behalf of a State or Territory government.

R4 Alcohol and drug treatment centres:

Freestanding centres for the treatment of drug dependence on an inpatient basis.

R5 Hostels and residential services:

Establishments run by public authorities or registered non-profit organisation to provide board, lodging or accommodation for the aged, distressed or disabled who cannot live independently but do not need nursing care in a hospital or nursing home. Only hostels subsidised by the Commonwealth are included. Separate dwellings are not included, even if subject to an individual rental rebate arrangement. Residents are generally responsible for their own provisions, but may be provided in some establishments with domestic assistance (meals, laundry, personal care). Night shelters providing only casual accommodation are excluded.

R6 Hospices:

Establishments providing palliative care to terminally ill patients. Only freestanding hospices which do not provide any other form of acute care are included in this category.

N7 Same-day establishments:

Includes both the traditional day centre/hospital and also freestanding day surgery centres.

Day centres/hospitals are establishments providing a course of acute treatment on a full-day or part-day non-residential attendance basis at specified intervals over a period of time. Sheltered workshops providing occupational or industrial training are excluded.

Freestanding day surgery centres are hospital facilities providing investigation and treatment for acute conditions on a day-only basis and are approved by the Commonwealth for the purposes of basic table health insurance benefits.

N8 Non-residential health services:

Services administered by public authorities or registered non-profit organisations which employ full-time equivalent medical or paramedical staff (nurses, nursing aides, physiotherapists, occupational therapists and psychologists, but not trade instructors or teachers). This definition distinguishes health services from welfare services (not within the scope of the National Minimum Data Project) and thereby excludes such services as sheltered workshops, special schools for the intellectually disabled, meals on wheels and baby clinics offering advisory services but no actual treatment. Non-residential health services should be enumerated in terms of services or organisations rather than in terms of the number of sites at which care is delivered.

Non-residential health services provided by a residential establishment (for example, domiciliary nursing service which is part of a public hospital) should not be separately enumerated.

N8.1 Community health centres:

Public or registered non-profit establishments in which a range of non-residential health services is provided in an integrated and coordinated manner, or which provides for the coordination of health services elsewhere in the community.

N8.2 Domiciliary nursing service:

Public or registered non-profit or profit-making establishments providing nursing or other professional paramedical care or treatment to patients in their own homes or in (non-health) residential institutions. Establishments providing domestic or housekeeping assistance are excluded by the general definition above.

Note that national minimum data sets currently include only community health centres and domiciliary nursing services.

Verification rules:**Collection methods:****Related metadata:****Administrative Attributes****Source document:**

Source organisation: National Health Data Committee

Information model link:

NHIM Organisation characteristic

Data Set Specifications:

	<i>Start date</i>	<i>End date</i>
NMDS - Alcohol and other drug treatment services	01/07/2002	30/06/2003
NMDS - Public hospital establishments	01/07/1989	

Comments:

In the current data element, the term establishment is used in a very broad sense to mean bases, whether institutions, organisations or the community from which health services are provided. Thus, the term covers conventional health establishments and also organisations which may provide services in the community.

This data element is currently under review by the Organisational Units Working Group of the National Health Data Committee. Recommendations will provide a comprehensive coverage of the health service delivery sector.

Estimated date flag

Identifying and Definitional Attributes

Knowledgebase ID:	000431	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/00	
Definition:	An indication of whether any component of a reported date was estimated.	

Context: Provision of a date is often a mandatory requirement in data collections. However, at times, the actual date or part thereof is not known (e.g. date of birth or date of injury). This data element is designed to flag the part or parts of a date that have been estimated when a date provided is based on an approximation of the date in question rather than reporting of the actual date. This data element may assist with record linkage processes (for example when the date of birth is a component of the linkage key).

Relational and Representational Attributes

Datatype:	Alphabetic
Representational form:	Code
Representational layout:	AAA
Minimum size:	1
Maximum size:	3

Data domain:	A	Date estimated from reported age
	D	Day value in date was estimated
	DM	Day and month values in date were estimated
	DMY	All values (day, month, year) in date were estimated
	DY	Day and year values in date were estimated
	M	Month value (only) in date was estimated
	MY	Month and year values in date were estimated
	Null	Date not estimated
	Y	Year value (only) in date was estimated

Guide for use: May be used to record an estimated date for date of birth or data elements for other dates such as date of death.

Verification rules:

Collection methods: This data element should be reported in conjunction with a reported date when any part of the date represents an estimate rather than the actual or known date.

Related metadata: is used in conjunction with Date of birth vers 4

Administrative Attributes

Source document:	
Source organisation:	National Health Data Committee

Information model link:

NHIM Demographic characteristic

Data Set Specifications:

DSS - Health care client identification

Start date**End date**

01/01/2003

Comments:

DSS - Health care client identification:

The use of a code V for a valid date could be useful in the determination of a positive identification of a health care client.

Extended wait patient

Identifying and Definitional Attributes

Knowledgebase ID:	000400	Version No:	1
Metadata type:	Derived Data Element		
Admin. status:	Current		
	01/07/99		
Definition:	A patient with the lowest level of clinical urgency for an awaited procedure who has been on the waiting list for elective surgery for more than one year.		
Context:	Elective surgery: The numbers and proportions of patients with extended waits are measures of hospital performance in relation to patient access to elective hospital care.		

Relational and Representational Attributes

Datatype:	Numeric		
Representational form:	Code		
Representational layout:	N		
Minimum size:	1		
Maximum size:	1		
Data domain:	1	Extended wait patient	
	2	Other patient	
Guide for use:	A patient is classified as an extended wait patient if the patient is clinical urgency category 3 at the time of admission or at a census time and has been waiting for elective surgery for more than one year.		
Verification rules:			
Collection methods:			
Related metadata:	is qualified by Clinical urgency vers 2		
	is derived from Waiting time at a census date vers 2		
	is derived from Waiting time at removal from elective surgery waiting list vers 2		

Administrative Attributes

Source document:			
Source organisation:	National Health Data Committee		
Information model link:	NHIM Performance indicator		
Data Set Specifications:	Start date	End date	
NMDS - Elective surgery waiting times	01/07/1999		

Comments:	This data item is used to identify clinical urgency category 3 patients who had waited longer than one year at admission or have waited longer than one year at the time of a census. An extended wait patient is not an 'Overdue patient' as there is no maximum desirable waiting time specified for patients in clinical urgency category 3 as they have been assessed as not having a clinically urgent need for the awaited procedure.
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External cause – admitted patient

Identifying and Definitional Attributes

Knowledgebase ID:	000053	Version No: 4
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/98	
Definition:	Environmental event, circumstance or condition as the cause of injury, poisoning and other adverse effect.	

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

Relational and Representational Attributes

Datatype:	Alphanumeric
Representational form:	Code
Representational layout:	ANN.NN
Minimum size:	3
Maximum size:	6

Data domain:	ICD-10-AM 3rd edition
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Guide for use:	<p>This code must be used in conjunction with an injury or poisoning codes and can be used with other disease codes. Admitted patients should be coded to the complete ICD-10-AM classification.</p> <p>An external cause code should be sequenced following the related injury or poisoning code, or following the group of codes, if more than one injury or condition has resulted from this external cause. Provision should be made to record more than one external cause if appropriate. External cause codes in the range W00 to Y34, except Y06 and Y07 must be accompanied by a place of occurrence code (data element Place of occurrence of external cause). External cause codes V01 to Y34 must be accompanied by an activity code (data element Activity when injured).</p>
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Verification rules:	As a minimum requirement, the external cause codes must be listed in the ICD-10-AM classification.
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Collection methods:

Related metadata:	is used in conjunction with Activity when injured vers 2
	is used in conjunction with Additional diagnosis vers 4
	relates to the data element Diagnosis onset type vers 1
	supersedes previous data element External cause – admitted patient – ICD-9-CM code vers 3
	is used in conjunction with Place of occurrence of external cause vers 2
	is used in conjunction with Principal diagnosis vers 3

Administrative Attributes

Source document: International Classification of Diseases – Tenth Revision – Australian Modification (3rd edition 2002) National Centre for Classification in Health, Sydney.

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

Information model link:

NHIM Injury event

Data Set Specifications:	Start date	End date
NMDS – Admitted patient care	01/07/1998	
NMDS – Injury surveillance	01/07/1998	

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

External cause – human intent

Identifying and Definitional Attributes

Knowledgebase ID:	000382	Version No:	4
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/98		
Definition:	The most likely role of human intent in the occurrence of the injury or poisoning as assessed by clinician.		

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

Datatype:	Numeric
Representational form:	Code
Representational layout:	NN
Minimum size:	2
Maximum size:	2

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

Guide for use:	Select the item which best characterises the role of intent in the occurrence of the injury, on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one that comes first in the code list. This item must always be accompanied by an External cause – non-admitted patient code. This data domain is for use in injury surveillance purposes only, when it is not possible to use a complete ICD-10-AM code (e.g. non-admitted patients in emergency departments).
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Verification rules:	
Collection methods:	

Related metadata:

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

Administrative Attributes

Source document:

Source organisation:

National Health Data Committee

National Data Standards for Injury Surveillance Advisory Group

Information model link:

NHIM Injury event

Data Set Specifications:

NMDS – Injury surveillance

Start date

End date

01/07/1998

Comments:

External cause – non-admitted patient

Identifying and Definitional Attributes

Knowledgebase ID:	000381	Version No:	4
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/98		
Definition:	Event, circumstance or condition associated with the occurrence of injury, poisoning or adverse effect.		

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

Datatype:	Numeric
Representational form:	Code
Representational layout:	NN
Minimum size:	2
Maximum size:	2

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

- 23 (deleted)
- 24 Machinery in operation
- 25 Electricity
- 26 Hot conditions (natural origin) sunlight
- 27 Cold conditions (natural origins)
- 28 Other specified external cause
- 29 Unspecified external cause
- 30 Struck by or collision with person
- 31 Struck by or collision with object

Guide for use:

This data domain is for use in injury surveillance purposes only, when it is not possible to use a complete ICD-10-AM code (e.g. Non-admitted patients in emergency departments). Select the item which best characterises the circumstances of the injury, on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate select the one that comes first in the code list. The External cause – non-admitted patient group must always be accompanied by an External cause – human intent code (see data element External cause – human intent).

Verification rules:**Collection methods:****Related metadata:**

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

Administrative Attributes**Source document:****Source organisation:**

National Health Data Committee
 National Centre for Classification in Health
 National Data Standards for Injury Surveillance Advisory Group

Information model link:

NHIM Injury event

Data Set Specifications:**Start date****End date****Comments:**

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