

Data elements

F – G

Family name

Identifying and Definitional Attributes

Knowledgebase ID: 000781 **Version No:** 1

Metadata type: Data Element

Admin. status: Current
01/01/03

Definition: That part of a name a person usually has in common with some other members of his/her family, as distinguished from her/his given names.

Context:

Relational and Representational Attributes

Datatype: Alphabetic

Representational form: Text

Representational layout: A(40)

Minimum size: 1

Maximum size: 40

Data domain: Text

Guide for use:

Verification rules:

Collection methods: Mixed case should be used.

Family name should be recorded in the format preferred by the person. The format should be the same as that written by the person on a (pre) registration form or in the same format as that printed on an identification card, such as Medicare card, to ensure consistent collection of name data.

It is acknowledged that some people use more than one family name (e.g. formal name, birth name, married/maiden name, tribal name) depending on the circumstances. Each name should be recorded against the appropriate Name type.

A person is able to change his or her name by usage in all States and Territories of Australia with the exception of Western Australia, where a person may change his or her name under the Change of Name Act. Care should be taken when recording a change of name for a minor. Ideally, the name recorded for the minor should be known to both of his/her parents, so the minor's records can be retrieved and continuity of care maintained, regardless of which parent accompanies the minor to the health care establishment.

A person should generally be registered using their preferred name as it is more likely to be used in common usage and on subsequent visits to the health care establishment. The person's preferred name may in fact be the name on their Medicare card. The Name type data element can be used to distinguish between the different types of names that may be used by the person. The following format may assist with data collection:

What is your family name? _____

Are you known by any other family names that you would like recorded? If so, what are they? _____

Please indicate, for each name above, the 'type' of family name that is to be recorded:

(a) Medicare card name (if different to preferred name).

(b) Alias (any other name that you are known by). Whenever a person informs the establishment of a change of family name (e.g. following marriage or divorce), the former name should be recorded as an alias name. A full history of names should be retained. e.g. 'Mary Georgina Smith' informs the hospital that she has been married and changed her family name to 'Jones'. Record 'Jones' as her preferred family name and record 'Smith' as an alias name.

Hyphenated family names:

Sometimes persons with hyphenated family names use only one of the two hyphenated names. It is useful to record each of the hyphenated names as an Alias. If the person has a hyphenated family name, e.g. 'Wilson-Phillips' record 'Wilson-Phillips' in the preferred family name field and record 'Wilson' and 'Phillips' separately as alias family names.

Registered unnamed newborn babies:

When registering a newborn, use the mother's family name as the baby's family name unless instructed otherwise by the mother. Record unnamed babies under the newborn Name type.

Persons with only one name:

Some people do not have a family name and a given name, they have only one name by which they are known. If the person has only one name, record it in the Family name field and leave the Given name field blank.

Registering an unidentified health care client:

The default for unknown family name, should be 'Unknown' in all instances and the name recorded as an alias name. Don't create a 'fictitious' family name such as 'Doe' as this is an actual family name. When the person's name becomes known, record it as the preferred family name and do not overwrite the alias name of 'Unknown'.

Registering health care clients from disaster sites:

Persons treated from disaster sites should be recorded under the alias name type. Local business rules should be developed for consistent recording of disaster site person details.

Care should be taken not to use identical dummy data (family name, given name, date of birth, sex) for two or more persons from a disaster site.

If the family name needs to be shortened:

If the length of the family name exceeds the length of the field, truncate the family name from the right (that is, dropping the final letters). Also, the last character of the name should be a hash (#) to identify that the name has been truncated.

Use of incomplete names or fictitious names:

Some health care facilities permit persons to use a pseudonym (fictitious or partial name) in lieu of their full or actual name. It is recommended that the person be asked to record both the pseudonym (alias name) in addition to the person's Medicare card name.

Baby for adoption:

The word 'Adoption' should not be used as the family name, given name or alias for a newborn baby. A newborn baby that is for adoption should be registered in the same way that other newborn babies are registered. However, if a baby born in the hospital is subsequently adopted, and is admitted for treatment as a child, the baby is registered under their adopted (current) name, and the record should not be linked to the birth record. This should be the current practice. Any old references to 'Adoption' in client registers (for names) should also be changed to 'Unknown'. Contact your State or Territory adoption information service for further information.

Prefixes:

Where a family name contains a prefix, such as one to indicate that the person is a widow, this must be entered as part of the Family name field. When widowed, some Hungarian women add 'Ozvegy' (abbreviation is 'Ozy') before their married family name, e.g. 'Mrs Szabo' would become 'Mrs Ozy Szabo'. That is, 'Mrs Szabo' becomes an alias name and 'Mrs Ozy Szabo' becomes the preferred name.

Ethnic names:

The Centrelink publication, *Naming Systems for Ethnic Groups*, provides the correct coding for ethnic names.

Misspelled family name:

If the person's family name has been misspelled in error, update the family name with the correct spelling and record the misspelled family name as an alias name. Recording misspelled names is important for filing documents that may be issued with previous versions of the person's name. Discretion should be used regarding the degree of recording that is maintained.

Related metadata:

relates to the data element Given name(s) vers 1

relates to the data element concept Name vers 1

relates to the data element Name context flag vers 1

relates to the data element Name suffix vers 1

relates to the data element Name title vers 1

relates to the data element Name type vers 1

Administrative Attributes

Source document: AS5017 Health care client identification, with adaptations.

Source organisation: Standards Australia

Information model link:

NHIM Person characteristic

Data Set Specifications:

DSS - Health care client identification

Start date

End date

01/01/2003

Comments:

Fasting status

Identifying and Definitional Attributes

Knowledgebase ID:	000665	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	The fasting status of the patient at the time of an examination, test, investigation or procedure.		
Context:	Public health, health care and clinical setting.		

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>Fasting</td> </tr> <tr> <td>2</td> <td>Non-fasting</td> </tr> <tr> <td>9</td> <td>Not stated/inadequately described</td> </tr> </table>	1	Fasting	2	Non-fasting	9	Not stated/inadequately described
1	Fasting						
2	Non-fasting						
9	Not stated/inadequately described						

Guide for use:

Verification rules:

Collection methods:

Related metadata:

- is used in conjunction with Cholesterol-HDL – measured vers 1
- is used in conjunction with Cholesterol-total – measured vers 1
- relates to the data element Dyslipidaemia – treatment vers 1
- is used in conjunction with Triglycerides – measured vers 1

Administrative Attributes

Source document:

Source organisation: National Diabetes Data Working Group
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	
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.

First day of the last menstrual period

Identifying and Definitional Attributes

Knowledgebase ID:	000056	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/96		
Definition:	Date of the first day of the mother's last menstrual period (LMP).		

Context:	Perinatal statistics: The first day of the LMP is required to estimate gestational age, which is a key outcome of pregnancy and an important risk factor for neonatal outcomes. Although the date of the LMP may not be known, or may sometimes be erroneous, estimation of gestational age based on clinical assessment may also be inaccurate. Both methods of assessing gestational age are required for analysis of outcomes.
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Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Date
Representational layout:	DDMMYYYY
Minimum size:	8
Maximum size:	8
Data domain:	Valid dates or 99999999 if first day is unknown
Guide for use:	If the first day is unknown, it is unnecessary to record the month and year (i.e. record 99999999).
Verification rules:	
Collection methods:	
Related metadata:	is used in the calculation of Gestational age 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	
NMDS - Perinatal	01/07/1997		

Comments:

Food supplies

Identifying and Definitional Attributes

Knowledgebase ID:	000240	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/89		
Definition:	The cost of all food and beverages but not including kitchen expenses such as utensils, cleaning materials, cutlery and crockery. 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:

Foot deformity

Identifying and Definitional Attributes

Knowledgebase ID:	000819	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	Presence of foot deformity on either foot. Common deformities include claw toes, pes cavus, hallux valgus, hallux rigidus, hammer toe, Charcot foot and nail deformity.		
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, foot deformity present</td> </tr> <tr> <td>2</td> <td>No, foot deformity not present</td> </tr> <tr> <td>9</td> <td>Not stated/inadequately described</td> </tr> </table>	1	Yes, foot deformity present	2	No, foot deformity not present	9	Not stated/inadequately described
1	Yes, foot deformity present						
2	No, foot deformity not present						
9	Not stated/inadequately described						
Guide for use:	Record whether or not a foot deformity is present in the person.						
Verification rules:							
Collection methods:	Both feet to be examined for the presence of foot deformity.						
Related metadata:	<p>relates to the data element Health professionals attended – diabetes mellitus vers 1</p> <p>relates to the data element Foot lesion – active vers 1</p> <p>relates to the data element Foot ulcer – history vers 1</p> <p>relates to the data element Lower limb amputation due to vascular disease vers 1</p> <p>relates to the data element Peripheral neuropathy – status vers 1</p> <p>relates to the data element Peripheral vascular disease in feet – status vers 1</p>						

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:

DSS – Diabetes (clinical)

Start date

01/01/2003

End date**Comments:**

Foot deformities are associated with high mechanical pressure on the overlying skin that lead to ulceration in the absence of protective pain sensation and when shoes are unsuitable. Limited joint mobility is often present, with displaced plantar fat pad and more prominent metatarsal heads. Foot deformities are frequently the result of diabetic motor neuropathy and diabetic foot disease is the most common cause of hospitalisation in people with diabetes.

Diabetic foot complications are common in the elderly, and amputation rates increase with age: by threefold in those aged 45–74 years and sevenfold over 75 years. In people with diabetes, amputations are 15 times more common than in people without diabetes and 50% of all amputations occur in people with diabetes (Epidemiology of the diabetic foot; Report of the Diabetic Foot and Amputation Group). All patients with diabetes mellitus should be instructed about proper foot care in an attempt to prevent ulcers. Feet should be kept clean and dry at all times. Patients with neuropathy should not walk barefoot, even in the home. Properly fitted shoes are essential.

Specialised foot clinics appear to decrease further episodes of foot ulceration and decrease hospital admissions for amputations.

Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus recommendations include:

- feet should be examined every 6 months or at every visit if high-risk foot or active foot problem
- refer to specialists experienced in the care of the diabetic foot if infection or ulceration is present
- ensure that patients with ‘high-risk foot’ or an active foot problem receive appropriate care from specialists and podiatrists expert in the treatment of diabetic foot problems
- to identify the ‘high-risk foot’ as indicated by a past history of foot problems, especially ulceration, and/or the presence of Peripheral neuropathy
- assessment outcome, peripheral vascular disease, or foot deformity or history of previous ulceration.

References:

Lesley V Campbell, Antony R Graham, Rosalind M Kidd, Hugh F Molloy, Sharon R O’Rourke and Stephen Colagiuri: The Lower Limb in People With Diabetes; Content 1997/98 Australian Diabetes Society.

Edmonds M, Boulton A, Buckenham T, et al. Report of the Diabetic Foot and Amputation Group. Diabet Med 1996; 13: S27–42.

Reiber GE. Epidemiology of the diabetic foot. In: Levin ME, O’Neal LW, Bowker JH, editors. The diabetic foot. 5th ed. St Louis: Mosby Year Book, 1993; 1–5.

Most RS, Sinnock P. The epidemiology of lower limb extremity amputations in diabetic individuals. Diabetes Care 1983; 6: 87–91.

Therapeutic Guidelines Limited (05.04.2002) Management plan for diabetes.

Foot lesion – active

Identifying and Definitional Attributes

Knowledgebase ID:	000820	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	Whether an individual has an active foot lesion other than an ulcer on either foot. The following entities would be included: fissures, infections, inter-digital maceration, corns, calluses and nail dystrophy.		
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, foot lesion present</td> </tr> <tr> <td>2</td> <td>No, foot lesion not present</td> </tr> <tr> <td>9</td> <td>Not stated/inadequately described</td> </tr> </table>	1	Yes, foot lesion present	2	No, foot lesion not present	9	Not stated/inadequately described
1	Yes, foot lesion present						
2	No, foot lesion not present						
9	Not stated/inadequately described						
Guide for use:	Record whether or not a current active foot lesion other than ulceration is present on either foot in the person.						
Verification rules:							
Collection methods:	Assess whether the individual has an active foot lesion on either foot.						
Related metadata:	<ul style="list-style-type: none"> relates to the data element Foot deformity vers 1 relates to the data element Foot ulcer – current vers 1 relates to the data element Foot ulcer – history vers 1 relates to the data element Lower limb amputation due to vascular disease vers 1 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:

DSS – Diabetes (clinical)

Start date

01/01/2003

End date**Comments:**

Early detection and appropriate management of the 'high-risk foot' and active foot problems can reduce morbidity, hospitalisation and amputation in people with diabetes.

All patients with diabetes mellitus should be instructed about proper foot care in an attempt to prevent ulcers or other problems that may result in the need for amputation. Feet should be kept clean and dry at all times. Patients with neuropathy should not walk barefoot, even in the home. Properly fitted shoes are essential.

Following the Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus foot examination:

- Inspect the feet (whole foot, nails, between the toes) to identify active foot problems and the 'high-risk foot'.
- Assess footwear.
- Check peripheral pulses.
- Examine for neuropathy by testing reflexes and sensation preferably using tuning fork, 10 g monofilament and/or biothesiometer
- Ask the patient about current foot problems, neuropathic symptoms, rest pain and intermittent claudication.

Foot ulcer – current

Identifying and Definitional Attributes

Knowledgebase ID:	000821	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	Whether an individual has a current foot ulcer on either foot.		
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, foot ulcer present</td> </tr> <tr> <td>2</td> <td>No, foot ulcer not present</td> </tr> <tr> <td>9</td> <td>Not stated/inadequately described</td> </tr> </table>	1	Yes, foot ulcer present	2	No, foot ulcer not present	9	Not stated/inadequately described
1	Yes, foot ulcer present						
2	No, foot ulcer not present						
9	Not stated/inadequately described						
Guide for use:	Record whether or not a foot ulcer is present on either foot in the person.						
Verification rules:							
Collection methods:	Assess whether the individual has a current foot ulcer on either foot.						
Related metadata:	<p>relates to the data element Health professionals attended – diabetes mellitus vers 1</p> <p>relates to the data element Foot deformity vers 1</p> <p>relates to the data element Foot lesion – active vers 1</p> <p>relates to the data element Foot ulcer – history vers 1</p> <p>relates to the data element Lower limb amputation due to vascular disease vers 1</p> <p>relates to the data element Peripheral neuropathy – status vers 1</p> <p>relates to the data element Peripheral vascular disease in feet – status vers 1</p>						

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

Comments:

Foot ulcer is usually situated on the edge of the foot or toes because blood supply is the poorest at these sites. In a purely vascular ulcer, nerve function is normal and sensation is intact, hence vascular ulcers are usually painful.

Foot ulcers require urgent care from an interdisciplinary team, which may include a general practitioner, podiatrist, endocrinologist physician, nurse or surgeon.

Assessment

- Ask the patient about previous or current foot problems, neuropathic symptoms, rest pain and intermittent claudication.
- Inspect the feet (whole foot, nails, between the toes) to identify active foot problems and the 'high-risk foot'.
- Assess footwear.
- Check peripheral pulses.
- Examine for neuropathy by testing reflexes and sensation preferably using tuning fork, 10 g monofilament and/or biothesiometer.

The development of ulcers of the feet and lower extremities is a special problem in the diabetic patient, and appears to be due primarily to abnormal pressure distribution secondary to diabetic neuropathy.

Diabetic foot ulceration is a serious problem and the lack of pain does not mean that the ulcer can be ignored or neglected. The absence of pain is very common in people with diabetes due to peripheral neuropathy.

All patients with diabetes mellitus should be instructed about proper foot care in an attempt to prevent ulcers. Feet should be kept clean and dry at all times. Patients with neuropathy should not walk barefoot, even in the home. Properly fitted shoes are essential.

Early detection and appropriate management of the 'high-risk foot' and current foot ulceration can reduce morbidity, hospitalisation and amputation in people with diabetes.

References:

The Diabetic Foot Vol. 3 No. 4 Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus

Foot ulcer – history

Identifying and Definitional Attributes

Knowledgebase ID:	000822	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	Whether or not person has a previous history of foot ulceration on either foot.		
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:	<p>1 Yes, history of foot ulceration</p> <p>2 No, no history of foot ulceration</p> <p>9 Not stated/inadequately described</p>
Guide for use:	Record whether or not the person has a history of foot ulceration.
Verification rules:	
Collection methods:	Ask the individual if he/she a previous history of foot ulceration. Alternatively obtain this information from appropriate documentation.
Related metadata:	<p>relates to the data element Health professionals attended – diabetes mellitus vers 1</p> <p>relates to the data element Foot deformity vers 1</p> <p>relates to the data element Foot lesion – active vers 1</p> <p>relates to the data element Foot ulcer – current vers 1</p> <p>relates to the data element Lower limb amputation due to vascular disease vers 1</p> <p>relates to the data element Peripheral neuropathy – status vers 1</p> <p>relates to the data element Peripheral vascular disease in feet – status vers 1</p>

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:

DSS - Diabetes (clinical)

Start date

01/01/2003

End date**Comments:**

Past history of foot ulceration, peripheral neuropathy and foot deformities have been associated with increased risk of foot ulceration and lower limb amputation for patients who suffer from diabetes. The aim is to identify the 'high-risk foot' as indicated by a past history of foot problems, especially ulceration.

Following the Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus, individuals with a 'high-risk foot' or a significant active foot problem should be examined every six months or at every visit.

Assessment

- Ask patient about previous foot problems, neuropathic symptoms, rest pain and intermittent claudication.
- Inspect the feet (whole foot, nails, between the toes) to identify active foot problems and the 'high-risk foot'.
- Assess footwear.
- Check peripheral pulses.
- Examine for neuropathy by testing reflexes and sensation preferably using tuning fork, 10 g monofilament and/or biothesiometer.

Formal community support access status

Identifying and Definitional Attributes

Knowledgebase ID:	000660	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	Identifies a person who is currently accessing a formal community support service or services.		
Context:	Personal and social support and clinical settings: This data element provides information about the use of formal community support services by clients.		

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>Currently accessing</td> </tr> <tr> <td>2</td> <td>Currently not accessing</td> </tr> <tr> <td>9</td> <td>Not known/inadequately described</td> </tr> </table>	1	Currently accessing	2	Currently not accessing	9	Not known/inadequately described
1	Currently accessing						
2	Currently not accessing						
9	Not known/inadequately described						
Guide for use:	<p>Code 1 The person is currently accessing at least one paid community support service (i.e. meals on wheels, home help, in-home respite, service packages, district nursing services, etc.).</p> <p>Code 2 The person is not currently accessing any paid community support service or services.</p> <p>Code 9 The person's current status with regards to accessing community support services is not known or inadequately described for more specific coding.</p>						
Verification rules:							
Collection methods:							
Related metadata:	<p>relates to the data element Carer availability vers 3</p> <p>relates to the data element Living arrangement vers 1</p> <p>is used in conjunction with Service contact date vers 1</p>						

Administrative Attributes

Source document:		
Source organisation:	CV-Data Working Group	
Information model link:		
	NHIM Request for/entry into service event	
Data Set Specifications:		Start date End date
	DSS - Cardiovascular disease (clinical)	01/01/2003

Comments:

Full-time equivalent staff

Identifying and Definitional Attributes

Knowledgebase ID: 000252 **Version No:** 2

Metadata type: Derived Data Element

Admin. status: Current
01/07/97

Definition: Full-time equivalent staff units are the on-job hours paid for (including overtime) and hours of paid leave of any type for a staff member (or contract employee where applicable) divided by the number of ordinary-time hours normally paid for a full-time staff member when on the job (or contract employee where applicable) under the relevant award or agreement for the staff member (or contract employee occupation where applicable). Hours of unpaid leave are to be excluded.

Contract staff employed through an agency are included where the contract is for the supply of labour (e.g. nursing) rather than of products (e.g. photocopier maintenance). In the former case, the contract would normally specify the amount of labour supplied and could be reported as full-time equivalent units.

Context: Health expenditure:

To assist in analyses of the resource use and activity of public hospital establishments. Inclusion of these data, classified by staffing category, allows analysis of costs per unit of labour and analysis of staffing inputs against establishment outputs.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNNNN

Minimum size: 1

Maximum size: 5

Data domain: Calculated number of staff (full-time equivalents) for each of the staffing categories listed in the Guide for use.

Guide for use: Staffing categories:

- C1.1 Salaried medical officers
- C1.2 Registered nurses
- C1.3 Enrolled nurses
- C1.4 Student nurses
- C1.5 Trainee/pupil nurses
- C1.6 Other personal care staff
- C1.7 Diagnostic and health professionals
- C1.8 Administrative and clerical staff
- C1.9 Domestic and other staff

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

If under the relevant award of agreement a full-time nurse is paid for an 80 (ordinary-time) hour fortnight, the full-time equivalent for a part-time nurse who works 64 hours is 0.8. If a full-time nurse under the same award is paid for 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25.

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each. (Salary costs should be apportioned on the same basis.)

Verification rules:

Collection methods:

Related metadata: supersedes previous data element Total full-time equivalent staff vers 1

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Recurrent expenditure

Data Set Specifications:

	<i>Start date</i>	<i>End date</i>
NMDS - Public hospital establishments	01/07/1997	
NMDS - Community mental health establishments	01/07/1998	

Comments:

This metadata item was amended during 1996-97. Until then, both average and end-of-year counts of full-time equivalent staff were included, and the end-of-year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Funding source for hospital patient

Identifying and Definitional Attributes

Knowledgebase ID:	000632	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/01		
Definition:	Expected principal source of funds for an admitted patient episode or non-admitted patient service event.		
Context:	Admitted patient care. Hospital non-admitted patient care.		

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 Australian Health Care Agreements 02 Private health insurance 03 Self-funded 04 Worker's compensation 05 Motor vehicle third party personal claim 06 Other compensation (e.g. public liability, common law, medical negligence) 07 Department of Veterans' Affairs 08 Department of Defence 09 Correctional facility 10 Other hospital or public authority (contracted care) 11 Reciprocal health care agreements (with other countries) 12 Other 99 Not known

Guide for use: The major funding source should be recorded if there is more than one source of funding. The final payment class recorded by the hospital should be used.

Australian Health Care Agreements (category 1) should be recorded as the funding source for admitted patients who elect to be treated as public patients. However, overseas visitors who are covered by a reciprocal health care agreement and elect to be treated as public patients (as detailed at www.health.gov.au/haf/docs/visthlth/2000hlth.htm#rhca) should be recorded as Reciprocal health care agreement (category 11).

Self-funded (category 3) includes funded by the patient, by the patient's family or friends, or by other benefactors.

Department of Veterans' Affairs (category 7) should be used for Department of Veterans' Affairs patients (as defined in the data element Department of Veterans' Affairs patient).

Compensable patients (as defined in the data element Compensable status), should be recorded as Worker's compensation (category 4), Motor vehicle third party personal claim (category 5) or Other compensation (category 6), as appropriate.

Overseas visitors for whom travel insurance is the major funding source should be recorded as Other (category 12).

Verification rules:

Collection methods:

Related metadata:

relates to the data element Admitted patient vers 3

relates to the data element Admitted patient election status vers 1

relates to the data element concept Non-admitted patient service event vers 1

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Insurance/benefit characteristic

Data Set Specifications:

NMDS - Admitted patient care

Start date

End date

01/07/2001

NMDS - Admitted patient palliative care

01/07/2001

Comments:

Geographical location of establishment

Identifying and Definitional Attributes

Knowledgebase ID:	000260	Version No:	2
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/97		
Definition:	Geographical location of the establishment. For establishments with more than one geographical location, the location is defined as that of the main administrative centre.		
Context:	Health services: To enable the analysis of service provision in relation to demographic and other characteristics of the population of a geographic area.		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	NNNNN
Minimum size:	5
Maximum size:	5
Data domain:	<i>Australian Standard Geographical Classification</i> (Australian Bureau of Statistics, Cat. No. 1216.0)
Guide for use:	<p>The geographical location is reported using a five digit numerical code to indicate the Statistical Local Area (SLA) within the reporting State or Territory, as defined in the Australian Standard Geographical Classification (ASGC). It is a composite of State identifier and SLA (first digit = State identifier, next four digits = SLA) for service delivery outlet.</p> <p>The ASGC is updated on an annual basis with a date of effect of 1 July each year. Therefore, the edition effective for the data collection reference year should be used.</p> <p>The Australian Bureau of Statistics' National Localities Index (NLI) can be used to assign each locality or address in Australia to an SLA. The NLI is a comprehensive list of localities in Australia with their full code (including SLA) from the main structure of the ASGC. For the majority of localities, the locality name (suburb or town, for example) is sufficient to assign an SLA. However, some localities have the same name. For most of these, limited additional information such as the postcode or State can be used with the locality name to assign the SLA.</p> <p>In addition, other localities cross one or more SLA boundaries and are referred to as split localities. For these, the more detailed information of the number and street of the establishment is used with the Streets Sub-index of the NLI to assign the SLA.</p>
Verification rules:	
Collection methods:	
Related metadata:	relates to the data element Establishment type vers 1 supersedes previous data element Geographic location vers 1

Administrative Attributes

Source document: Australian Standard Geographical Classification (Australian Bureau of Statistics, Cat. No. 1216.0)

Source organisation: National Health Data Committee

Information model link:

NHIM Address element

Data Set Specifications:	Start date	End date
NMDS - Alcohol and other drug treatment services	01/07/2002	30/06/2003
NMDS - Public hospital establishments	01/07/1997	
NMDS - Community mental health establishments	01/07/1998	

Comments: The geographical location does not provide direct information on the geographical catchment area or catchment population of the establishment.

Geographical location of service delivery outlet

Identifying and Definitional Attributes

Knowledgebase ID:	000823	Version No:	1
Metadata type:	Derived Data Element		
Admin. status:	Current		
	01/07/03		
Definition:	Geographical location of a site from which a health/community service is delivered.		
Context:	Alcohol and other drug treatment services: To enable the analysis of the accessibility of service provision in relation to demographic and other characteristics of the population of a geographic area.		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	NNNNN
Minimum size:	5
Maximum size:	5

Data domain: Australian Standard Geographical Classification (Australian Bureau of Statistics, Cat. No. 1216.0).

Guide for use: The geographical location is reported using a five digit numerical code to indicate the Statistical Local Area (SLA) within the reporting State or Territory, as defined in the Australian Standard Geographical Classification (ASGC). It is a composite of State identifier and SLA (first digit = State identifier, next four digits = SLA) for service delivery outlet.

The Australian Standard Geographical Classification (ASGC) is updated on an annual basis with a date of effect of 1 July each year. Therefore, the edition effective for the data collection reference year should be used.

The Australian Bureau of Statistics' National Localities Index (NLI) can be used to assign each locality or address in Australia to an SLA. The NLI is a comprehensive list of localities in Australia with their full code (including SLA) from the main structure of the ASGC. For the majority of localities, the locality name (suburb or town, for example) is sufficient to assign an SLA. However, some localities have the same name. For most of these, limited additional information such as the postcode or State can be used with the locality name to assign the SLA.

In addition, other localities cross one or more SLA boundaries and are referred to as split localities. For these, the more detailed information of the number and street of the establishment is used with the Streets Sub-index of the NLI to assign the SLA.

Verification rules:

Collection methods:

Related metadata: relates to the data element Service delivery outlet vers 1
is composed of State/Territory identifier vers 3

Administrative Attributes

Source document: Australian Standard Geographical Classification (ABS Cat. No. 1216.0)

Source organisation: Intergovernmental Committee on Drugs NMDS WG

Information model link:

NHIM Address element

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

Comments:

Gestational age

Identifying and Definitional Attributes

Knowledgebase ID: 000059 **Version No:** 1

Metadata type: Data Element Concept

Admin. status: Current
01/07/96

Definition: The duration of gestation is measured from the first day of the last normal menstrual period. Gestational age is expressed in completed days or completed weeks (e.g. events occurring 280 to 286 completed days after the onset of the last normal menstrual period are considered to have occurred at 40 weeks of gestation).

The World Health Organization identifies the following categories:

- Pre-term: less than 37 completed weeks (less than 259 days) of gestation
- Term: from 37 completed weeks to less than 42 completed weeks (259 to 293 days) of gestation
- Post-term: 42 completed weeks or more (294 days or more) of gestation.

Context: Perinatal.

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 Gestational age 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:

Gestational age

Identifying and Definitional Attributes

Knowledgebase ID:	000060	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/96		
Definition:	The estimated gestational age of the baby in completed weeks as determined by clinical assessment.		
Context:	Perinatal statistics: The first day of the LMP is required to estimate gestational age, which is a key outcome of pregnancy and an important risk factor for neonatal outcomes. Although the date of the LMP may not be known, or may sometimes be erroneous, estimation of gestational age based on clinical assessment may also be inaccurate. Both methods of assessing gestational age are required for analysis of outcomes.		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	NN
Minimum size:	2
Maximum size:	2
Data domain:	Number representing the number of completed weeks 99 Not stated/unknown.
Guide for use:	This is derived from clinical assessment when accurate information on the date of the last menstrual period (LMP) is not available for this pregnancy. Gestational age is frequently a source of confusion when calculations are based on menstrual dates. For the purposes of calculation of gestational age from the date of the first day of the last normal menstrual period and the date of delivery, it should be borne in mind that the first day is day zero and not day one.
Verification rules:	
Collection methods:	
Related metadata:	is calculated using First day of the last menstrual period vers 1 relates to the data element concept Gestational age vers 1

Administrative Attributes

Source document:	International Classification of Diseases and Related Health Problems, 10 Revision, WHO, 1992
Source organisation:	National Perinatal Data Development Committee
Information model link:	NHIM Physical wellbeing
Data Set Specifications:	Start date End date
NMDS - Perinatal	01/07/1997
Comments:	

Given name(s)

Identifying and Definitional Attributes

Knowledgebase ID:	000782	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	The person's identifying name(s) within the family group or by which the person is socially identified.		

Context:

Relational and Representational Attributes

Datatype:	Alphabetic
Representational form:	Text
Representational layout:	A(40)
Minimum size:	0
Maximum size:	40

Data domain: Text

Guide for use: Health care establishments may record given names (first and other given names) in one field or several fields. This data element definition applies regardless of the format of data recording.
A full history of names is to be retained.

Verification rules:

Collection methods: Given name(s) should be recorded in the format preferred by the person. The format should be the same as that written by the person on a (pre-) registration form or in the same format as that printed on an identification card, such as Medicare card, to ensure consistent collection of name data.

It is acknowledged that some people use more than one given name (e.g. formal name, birth name, nickname or shortened name, or tribal name) depending on the circumstances. A person is able to change his or her name by usage in all States and Territories of Australia with the exception of Western Australia, where a person may change his or her name under the Change of Name Act.

A person should generally be registered using their preferred name as it is more likely to be used in common usage and on subsequent visits to the health care establishment. The person's preferred name may in fact be their legal (or Medicare card) name. The Name type data element can be used to distinguish between the different types of names that may be used by the person.

The following format may assist with data collection:

What is the given name you would like to be known by?

Are you known by any other given names that you would like recorded?

If so, what are they?

Please indicate the 'type' of given name that is to be recorded:

(a) Medicare card name (if different to preferred name).

(b) Alias (any other name that you are known by).

Do not delete or overwrite a previous given name:

Whenever a person informs the establishment of a change of given name (e.g. prefers to be known by their middle name), the former name should be recorded according to the appropriate Name type.

Example - Georgina Smith' informs the hospital that she prefers to be known as 'Georgina'. Record 'Georgina' as her preferred Given name and record 'Mary' as the Medicare card Given name.

Example - The establishment is informed that 'Baby of Louise Jones' has been named 'Mary Jones'. Retain 'Baby of Louise' as the newborn name and also record 'Mary' as the preferred Given name.

Registering an unidentified health care client:

If the person is a health care client and her/his given name is not known record 'Unknown' in the Given name field and use alias name type. When the person's name becomes known, add the actual name as preferred Name type (or other as appropriate). Do not delete or overwrite the alias name of 'Unknown'.

Use of first initial:

If the person's given name is not known, but the first letter (initial) of the given name is known, record the first letter in the (preferred) Given name field. Do not record a full stop following the initial.

Persons with only one name:

Some people do not have a family name and a given name: they have only one name by which they are known. If the person has only one name, record it in the Family name field and leave the Given name blank.

Multiple given names (middle, second, third etc.names):

All of the person's given names should be recorded in the Given name field, leaving a space between each name.

Record complete information:

If the person has many given names and all of them cannot fit in the field, record as many names in full as possible, in preference to recording initials.

Shortened or alternate first given name:

If the person uses a shortened version or an alternate version of their first given name, record their preferred name, the actual name as their Medicare card name and any alternative versions as Alias names as appropriate.

Example - The person's given name is Jennifer but she prefers to be called Jenny. Record 'Jenny' as the preferred Given name and 'Jennifer' as her Medicare card name.

Example - The person's given name is 'Giovanni' but he prefers to be called 'John'. Record 'John' as the preferred Given name and 'Giovanni' as the Medicare card name.

Punctuation:

If special characters form part of the given names they shall be included.

- hyphen (e.g. Anne-Maree, Mary-Jane)

Hyphenated names shall be entered with the hyphen. Do not leave a space before or after the hyphen, i.e. between last letter of 'Anne' and the hyphen, nor a space between the hyphen and the first letter of 'Maree'.

- spaces e.g. Jean Claude

If the person has recorded a given name as more than one word, displaying spaces in between the words, record their given names in data collection systems in the same way.

- e.g. Oscar Peter, Wendy Hilda

Leave a single space between the person's first name and each of their middle names.

Registering an unnamed newborn baby:

An unnamed (newborn) baby is to be registered using the mother's given name in conjunction with the prefix 'Baby of'. For example, if the baby's mother's given name is Fiona, then record 'Baby of Fiona' in the (preferred) Given name field for the baby. This name is recorded under the newborn Name type. If a name is subsequently given, record the new name as the preferred Given name and retain the newborn name.

Registering unnamed multiple births:

An unnamed (newborn) baby from a multiple birth should use their mother's given name plus a reference to the multiple birth. For example, if the baby's mother's given name is 'Fiona' and a set of twins is to be registered, then record 'Twin 1 of Fiona' in the Given name field for the first-born baby, and 'Twin 2 of Fiona' in the Given name field of the second-born baby. Arabic numbers (1, 2, 3 ...) are used, not Roman numerals (I, II, III).

In the case of triplets or other multiple births the same logic applies. The following terms should be use for recording multiple births:

- Twin
Use Twin i.e. Twin 1 of Fiona
- Triplet
Use Trip i.e. Trip 1 of Fiona
- Quadruplet
Use Quad i.e. Quad 1 of Fiona
- Quintuplet
Use Quin i.e. Quin 1 of Fiona
- Sextuplet
Use Sext i.e. Sext 1 of Fiona
- Septuplet
Use Sept i.e. Sept 1 of Fiona

These names should be recorded under the newborn Name type. When the babies are named, the actual names should be recorded as the preferred name. The newborn name is retained.

Aboriginal/Torres Strait Islander names not for continued use:

For cultural reasons, an Aboriginal or Torres Strait Islander may advise an establishment that they are no longer using the given name that they had previously registered and are now using an alternative current name. Record their current name as the preferred Given name and record their previously recorded given name as an Alias name.

Ethnic names:

The Centrelink Naming Systems for Ethnic Groups publication provides the correct coding for ethnic names. Refer to Appendix A Ethnic Names Condensed Guide for summary information.

Misspelled given names:

If the person's given name has been misspelled in error, update the Given name field with the correct spelling and record the misspelled given name as an alias name. Recording misspelled names is important for filing documents that may be issued with previous versions of the client's name. Discretion should be used regarding the degree of recording that is maintained.

Related metadata:

- relates to the data element Family name vers 1
- relates to the data element Name vers 1
- relates to the data element Name context flag vers 1
- relates to the data element Name suffix vers 1
- relates to the data element Name title vers 1
- relates to the data element Name type vers 1

Administrative Attributes

Source document: AS5017 Health care client identification, with adaptation.

Source organisation: Standards Australia

Information model link:

NHIM Person characteristic

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

Comments:

Glycosylated haemoglobin (HbA1c) – measured

Identifying and Definitional Attributes

Knowledgebase ID:	000824	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	A person's measured glycosylated haemoglobin (HbA1c) level.		
Context:	Public health, health care and clinical settings.		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	NN.N
Minimum size:	3
Maximum size:	4
Data domain:	Measured in % to 1 decimal point 99.9 Not stated/inadequately described
Guide for use:	Record the absolute result of the test (%).
Verification rules:	
Collection methods:	Test is performed in accredited laboratories. <ul style="list-style-type: none"> • A single blood sample is sufficient and no preparation of the patient is required. • Measure HbA1c ideally using High Performance Liquid Chromatography (HPLC)
Related metadata:	relates to the data element Glycosylated haemoglobin (HbA1c) – upper limit of normal range 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 Service provision event	
Data Set Specifications:	Start date	End date
DSS – Diabetes (clinical)	01/01/2003	
Comments:	The HbA1c along with regular blood glucose monitoring is the best way to see the overall picture of blood glucose levels.	

HbA1c is a measurement of long-term blood glucose control and is used to assess the effectiveness of treatment. The level of HbA1c is proportional to the level of glucose in the blood over a period of approximately two months, because glucose attaches to the haemoglobin (red blood cells) and remains there for the life of the red blood cell, approximately 120 days. The HbA1c gives an average of the blood glucose level over the past 6–8 weeks and therefore haemoglobin A1c is accepted as an indicator of the mean daily blood glucose concentration over the preceding two months.

HbA1c is formed by the non-enzymatic glycation of the N-terminus of the B-chain of haemoglobin A_o. It is a convenient way to obtain an integrated assessment of antecedent glycaemia over an extended period under real life conditions used as a standard for assessing overall blood glucose control.

HbA1c results vary between laboratories; use the same laboratory for repeated testing

When reporting, record absolute result of the most recent HbA1c level in the last 12 months.

Research studies in the United States have found that for every 1% reduction in results of HbA1c blood tests, the risk of developing micro vascular diabetic complications (eye, kidney, and nerve disease) is reduced by 40%.

The maintenance of good glycaemic control (in diabetes Type 1 and Type 2), significantly reduces progression of diabetes-related complications such as retinopathy, nephropathy and neuropathy, as indicated in the 'Diabetes Control and Complications Trial' (DCCT 1993) and the 'United Kingdom Prospective Diabetes Study' (UKPDS 1997).

The target proposed by the Australian Diabetes Society for glycosylated haemoglobin (HbA1c) is 7.0% or less and a doctor may order this test about every 3–6 months.

References:

Koenig, R. J. Peterson, CM and Kilo, C et al. Hemoglobin A1c as an indicator of the degree of glucose intolerance in diabetes. *Diabetes* 259 (1976): 230–232.

Nathan, D.M., Singer, D.E, Hurxthal, K, and Goodson, J.D. The clinical information value of the glycosylated hemoglobin assay. *N. Eng. J. Med.* 310 (1984): 341–346.

Glycosylated haemoglobin (HbA1c) – upper limit of normal range

Identifying and Definitional Attributes

Knowledgebase ID:	000825	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	Laboratory standard for the value of glycosylated haemoglobin (HbA1c) that is the upper boundary of the normal reference range.		
Context:	Public health, health care and clinical settings.		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	NN.N
Minimum size:	3
Maximum size:	4
Data domain:	Measured in % 99.9 Not stated/inadequately described
Guide for use:	Record the upper limit of the HbA1c normal reference range from the laboratory result.
Verification rules:	
Collection methods:	This value is usually notified in patient laboratory results and may vary for different laboratories.
Related metadata:	relates to the data element Glycosylated haemoglobin (HbA1c) - 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 Service provision event		
Data Set Specifications:		Start date	End date
DSS – Diabetes (clinical)		01/01/2003	
Comments:	The upper limit of normal range is the laboratory standard for the maximum level of HbA1c, which is still in normal range. These figures vary between laboratories.		

HbA1c results vary between laboratories; use the same laboratory for repeated testing.

HbA1c is a measurement of long-term blood glucose control and is used to assess the effectiveness of treatment. It is a convenient way to obtain an integrated assessment of antecedent glycaemia over an extended period under real life conditions and is used as a standard for assessing overall blood glucose control. The target is to achieve an HbA1c within 1% of the upper limit of normal or achieve control as near to this target as possible without producing unacceptable hypoglycaemia as recommended from the Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus.

If HbA1c is 2% above the upper limit of normal, explore reasons for unsatisfactory control such as diet, intercurrent illness, appropriateness of medication, concurrent medication, stress, and exercise and review management:

- review and adjust treatment
- consider referral to diabetes educator
- consider referral to dietitian
- consider referral to endocrinologist or physician or diabetes centre.

Goal of care

Identifying and Definitional Attributes

Knowledgebase ID: 000111 **Version No:** 2

Metadata type: Data Element

Admin. status: Current
01/07/98

Definition: The goal or expected outcome of a plan of care, negotiated by the service provider and recipient, which outlines the overall aim of actions planned by a community service and relates to a person's health need. This goal reflects a total care plan and takes into account the possibility that a range of community services may be provided within a specified time frame.

Context: This item focuses on the broad goal which the person and services provider hope to achieve within an expected time period and takes into account the intervention or services provided by a range of community services.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NN

Minimum size: 2

Maximum size: 2

Data domain:

01	Well person for preventative/maintenance/health promotion program
02	Person will make a complete recovery
03	Person will not make a complete recovery, but will rehabilitate to a state where formal on-going service is no longer required
04	Person has a long-term care need and the goal is aimed at on-going support to maintain at home
05	Person in end-stage of illness the goal is aimed at support to stay at home in comfort and dignity and facilitation of choice of where to die
06	Person is unable to remain at home for extended period and goal is aimed at institutionalisation at a planned and appropriate time
07	For assessment only/not applicable

Guide for use:

01	service recipients are those making contact with the health service primarily as a part of a preventative/maintenance health promotion program. This means they are well and do not require care for established health problems. They include well antenatal persons attending or being seen by the service for screening or health education purposes.
02	describes those persons whose condition is self-limiting and from which complete recovery is anticipated, or those with established or long-term health problems who are normally independent in their management.

Goal 2 service recipient includes:

- post-surgical or acute medical service recipients whose care at home is to facilitate convalescence. Such admissions to home care occur as a result of early discharge from hospital; post-surgical complication such as wound infection; or because the person is at risk during the recovery phase and requires surveillance for a limited period;
- persons recovering from an acute illness and referred from the general practitioner or other community-based facility;

- persons with disability or established health problem normally independent of health services, and currently recovering from an acute condition or illness as above.
- 03 refers to those service recipients whose care plan is aimed at returning them to independent functioning at home either through self-care or with informal assistance, such that formal services will be discontinued. The distinguishing characteristic of this group is that complete recovery is not expected but some functional gain may be possible. Further, the condition is not expected to deteriorate rapidly or otherwise cause the client to be at risk without contact or surveillance from the community service.
- 04 refers to those service recipients whose health problem/condition is not expected to resolve and who will require ongoing maintenance care from the nursing service. Such clients are distinguished from those in Goal 3 in that their condition is of an unknown or long-term nature and not expected to cause death in the foreseeable future. They may require therapy for restoration of function initially and intermittently, and may also have intermittent admissions for respite. However, the major part of their care is planned to be at home.
- 05 refers to persons whose focus of care is palliation of symptoms and facilitation of the choice to die at home.
- 06 includes persons who have a limited ability to remain at home because of their intensive care requirements and the inability of formal and informal services to meet these needs. Admission to institutional care is therefore a part of the care planning process and the timing dependent upon the capacity and/or wish to remain at home. The distinguishing feature of this group is that the admission is not planned to be an intermittent event to boost the capacity for home care but is expected to be of a more permanent (or indeterminate) nature.
- Excluded from this group are persons with established health problems or permanent disability, if the contact is related to the condition. For example, persons with diabetes and in a diabetes program would be included in Goal 3; however, such persons would be included in Goal 6 if the contact with the service is not related to an established health problem but is primarily for preventative/maintenance care as described above.
- 07 service recipients are those for whom the reason for the visit is to undertake an assessment. This may include clients in receipt of a Domiciliary Nursing Care Benefit (DNCB) for whom the purpose of the visit is to determine ongoing DNCB eligibility and requirements for care. Implicit in this visit is review of the person's health status and circumstances, to ensure that their ongoing support does not place them or their carer at avoidable risk.

Verification rules:

Only one option is permissible and where Code 7 is selected, Code 9 must be used in Nursing interventions.

Collection methods:

At time of formal review of the client, the original Goal of care should be retained and not over-written by the system. The goal of care relates to the episode bounded by the Date of first contact with community nursing service and Date of last contact and in this format provides a focussing effect at the time of planning for care.

Related metadata:

relates to the data element Date of first contact vers 2
 relates to the data element Date of last contact vers 2
 relates to the data element Nursing diagnosis vers 2
 supersedes previous data element Nursing goal vers 1
 relates to the data element Nursing interventions vers 2

Administrative Attributes

Source document:

Source organisation: Australian Council of Community Nursing Services

Information model link:

NHIM Expected outcome

Data Set Specifications:

Start date

End date

Comments:

Agencies who had previously implemented this item should note changes to the code set in data domain.

Group sessions

Identifying and Definitional Attributes

Knowledgebase ID: 000210 **Version No:** 1

Metadata type: Derived Data Element

Admin. status: Current
01/07/89

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

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

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNNNNN

Minimum size: 1

Maximum size: 6

Data domain: Calculated number of group sessions

Guide for use:

Verification rules:

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

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
NMDS - Public hospital establishments	01/07/1989	

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