

Data Elements

P – R

Patient

Identifying and Definitional Attributes

Knowledgebase ID:	000117	Version No: 1
Metadata type:	Data Element Concept	
Admin. status:	Current	
	01/07/95	
Definition:	A patient is a person for whom a hospital accepts responsibility for treatment and/or care. There are two categories of patient – admitted and non-admitted patients. Boarders are not patients.	
Context:	Admitted patient care and public hospital establishments.	

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 Admitted patient vers 3

Administrative Attributes

Source document:		
Source organisation:	National Health Data Committee	
Information model link:	NHIM Recipient role	
Data Set Specifications:	Start date	End date

Comments:	While the concept of a person for whom a service provider accepts responsibility for treatment or care is also applicable to non-admitted patient and public hospital establishments care and to welfare services, different terminology is often used in these other care settings e.g. client, resident.
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Patient days

Identifying and Definitional Attributes

Knowledgebase ID:	000206	Version No: 3
Metadata type:	Derived Data Element	
Admin. status:	Current	
	01/07/00	
Definition:	The number of patient days is the total number of days for all patients who were admitted for an episode of care and who separated during a specified reference period.	
Context:	Admitted patient care: Needed as the basic count of the number of services provided by an establishment.	

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	NNNNNNNN
Minimum size:	1
Maximum size:	8

Data domain: Count of patient days for the period

Guide for use: A day is measured from midnight to 2359 hours.

The following basic rules are used to calculate the number of patient days for overnight stay patients:

- the day the patient is admitted is a patient day
- if the patient remains in hospital from midnight to 2359 hours, count as a patient day
- the day a patient goes on leave is counted as a leave day
- if the patient is on leave from midnight to 2359 hours, count as a leave day
- the day the patient returns from leave is counted as a patient day
- the day the patient is separated is not counted as a patient day.

The following additional rules cover special circumstances and in such cases, override the basic rules:

- patients admitted and separated on the same date (same-day patients) are to be given a count of one patient day
- if the patient is admitted and goes on leave on the same day, count as a patient day
- if the patient returns from leave and goes on leave on the same date, count as a leave day.
- if the patient returns from leave and is separated, it is not counted as either a patient day or a leave day

- if a patient goes on leave the day they are admitted and does not return from leave until the day they are discharged, count as one patient day (the day of admission is counted as a patient day, the day of separation is not counted as a patient day).

When calculating total patient days for a specified period:

- count the total patient days of those patients separated during the specified period including those admitted before the specified period
- do not count the patient days of those patients admitted during the specified period who did not separate until the following reference period
- contract patient days are included in the count of total patient days. If it is a requirement to distinguish contract patient days from other patient days, they can be calculated by using the rules contained in the data element Total contract patient days.

Verification rules:

Collection methods:

Related metadata:

relates to the data element Admission date vers 4
 relates to the data element Discharge date vers 4
 supersedes previous derived data element Patient days vers 2
 relates to the data element Total contract patient days vers 1
 relates to the data element Total leave days vers 3

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Performance indicator

Data Set Specifications:

Start date

End date

Comments:

Patient listing status

Identifying and Definitional Attributes

Knowledgebase ID: 000120 **Version No:** 3

Metadata type: Data Element

Admin. status: Current
01/07/97

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

Context:

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Ready for care
2	Not ready for care

Guide for use: Ready for care patients are those who are prepared to be admitted to hospital or to begin the process leading directly to admission. These could include investigations/procedures done on an outpatient basis, such as autologous blood collection, pre-operative diagnostic imaging or blood tests. Not ready for care patients are those who are not in a position to be admitted to hospital. These patients are either:

- staged patients whose medical condition will not require or be amenable to surgery until some future date; for example, a patient who has had internal fixation of a fractured bone and who will require removal of the fixation device after a suitable time, or
- deferred patients who for personal reasons are not yet prepared to be admitted to hospital; for example, patients with work or other commitments which preclude their being admitted to hospital for a time.

Not ready for care patients could be termed staged and deferred waiting list patients, although currently health authorities may use different terms for the same concepts.

Staged and deferred patients should not be confused with patients whose operation is postponed for reasons other than their own unavailability; for example, surgeon unavailable, operating theatre time unavailable owing to emergency workload. These patients are still 'ready for care'.

Periods when patients are not ready for care should be excluded in determining Waiting time at removal from elective surgery waiting list and Waiting time at a census date.

Verification rules:

Collection methods:

Related metadata:

- is a qualifier of Category reassignment date vers 2
- relates to the data element concept Hospital waiting list vers 2
- supersedes previous data element Patient listing status vers 2
- is used in conjunction with Waiting list category vers 3
- is a qualifier of Waiting time at removal from elective surgery waiting list vers 2

Administrative Attributes

Source document:

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

Information model link:

NHIM Request for/entry into service event

Data Set Specifications:	Start date	End date
NMDS - Elective surgery waiting times	01/07/1997	

Comments:

Only patients ready for care are to be included in the NMDS - Elective surgery waiting times. The dates when a patient listing status changes need to be recorded. A patient's classification may change if he or she is examined by a clinician during the waiting period, i.e. undergoes clinical review. The need for clinical review varies with the patient's condition and is therefore at the discretion of the treating clinician. The waiting list information system should be able to record dates when the classification is changed (data element Category reassignment date).

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

Patient presentation at emergency department

Identifying and Definitional Attributes

Knowledgebase ID: 000349 **Version No:** 1

Metadata type: Data Element Concept

Admin. status: Current
01/07/98

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

- registered clerically
- triaged.

Context: Institutional health care.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

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

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

Verification rules:

Collection methods:

Related metadata:

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Request for/entry into service event

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

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.

Patient revenue

Identifying and Definitional Attributes

Knowledgebase ID: 000296 **Version No:** 1

Metadata type: Data Element

Admin. status: Current
01/07/89

Definition: Patient revenue comprises all revenue received by, and due to, an establishment in respect of individual patient liability for accommodation and other establishment charges. All patient revenue is to be grouped together regardless of source of payment (Commonwealth, health fund, insurance company, direct from patient) or status of patient (whether inpatient or non-inpatient, private or compensable). Gross revenue should be reported.

Note: The Commonwealth contribution in respect of residential aged care service patients should be included under patient revenue.

Context: Health expenditure:
Patient revenue is a significant source of income for most establishments. For some establishments (principally the private sector) it is the major source of income. Patient revenue data is important for any health financing analyses or studies 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 as currency 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 minimum data set working parties

Information model link:

NHIM Financial resource item

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

NMDS - Public hospital establishments 01/07/1989

Comments:

Patient transport

Identifying and Definitional Attributes

Knowledgebase ID:	000243	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/89	
Definition:	The direct cost of transporting patients excluding salaries and wages of transport staff.	
Context:	Health expenditure: Considered to be a significant element of non-salary recurrent expenditure for many 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 as currency 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 minimum data set working parties		
Information model link:	NHIM Recurrent expenditure		
Data Set Specifications:		Start date	End date
	NMDS - Public hospital establishments	01/07/1989	

Comments:

Patients in residence at year end

Identifying and Definitional Attributes

Knowledgebase ID: 000208 **Version No:** 1

Metadata type: Derived Data Element

Admin. status: Current
01/07/89

Definition: A headcount of all formally admitted patients/clients in residence in long-stay facilities (public psychiatric hospitals, alcohol and drug hospitals, residential aged care services) at midnight, to be done on 30 June.

Context: The number of separations and bed days for individual long-stay establishments is often a poor indication of the services provided. This is because of the relatively small number of separations in a given institution. Experience has shown that the number of patients/clients in residence can often give a more reliable picture of the levels of services being provided.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNNN

Minimum size: 1

Maximum size: 4

Data domain: Count of admitted patients/clients in residence

Guide for use:

Verification rules:

Collection methods: For public psychiatric hospitals and alcohol and drug hospitals, all States have either an annual census or admission tracking that would enable a statistical census. The Commonwealth Department of Health and Family Service is able to carry out a statistical census from its residential aged care service databases.

A headcount snapshot could be achieved either by census or by the admission/discharge derivation approach.

There are difficulties with the snapshot in view of both seasonal and day of the week fluctuations. Most of the traffic occurs in a small number of beds.

Any headcount should avoid the problems associated with using 31 December or 1 January. The end of the normal financial year is probably more sensible (the Wednesday before the end of the financial year was suggested, but probably not necessary). This should be qualified by indicating that the data does not form a time series in its own right.

Related metadata: relates to data element concept Admitted patient vers 3

Administrative Attributes

Source document:

Source organisation: Morbidity Working Party

Information model link:

NHIM Performance indicator

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

Comments:

Payments to visiting medical officers

Identifying and Definitional Attributes

Knowledgebase ID:	000236	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/89		
Definition:	<p>All payments made by an institutional health care establishment to visiting medical officers for medical services provided to hospital (public) patients on an honorary, sessionally paid, or fee for service basis.</p> <p>A visiting medical officer is a medical practitioner appointed by the hospital board to provide medical services for hospital (public) patients on an honorary, sessionally paid, or fee for service basis. This category includes the same Australian Standard Classification of Occupations codes as the salaried medical officers category.</p>		
Context:	<p>Health expenditure:</p> <p>This is a significant element of expenditure for many hospitals (although not for other establishments) and needed for health financing and health expenditure analysis at the national level. Any analysis of health expenditures at the national level would tend to break down if significant components of expenditure were not available.</p>		

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 as currency 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 minimum data set working parties		
Information model link:	NHIM Recurrent expenditure		
Data Set Specifications:	Start date	End date	
NMDS - Public hospital establishments	01/07/1989		
Comments:	Although accepting the need to include visiting medical officer payments, the Resources Working Party decided not to include data on visiting medical officer services (whether hours or number of sessions or number of services		

provided) due to collection difficulties and the perception that use of visiting medical officers was purely a hospital management issue.

Perinatal period

Identifying and Definitional Attributes

Knowledgebase ID:	000124	Version No: 1
Metadata type:	Data Element Concept	
Admin. status:	Current	
	01/07/96	
Definition:	The perinatal period commences at 20 completed weeks (140 days) of gestation and ends 28 completed days after birth.	
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:	

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:	<p>This definition of perinatal period differs from that recommended by the World Health Organization (WHO). In the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (WHO 1992) the perinatal period is defined as commencing 'at 22 completed weeks (154 days) of gestation (the time when birthweight is normally 500 g) and ends seven completed days after birth'.</p> <p>At the time that WHO first recommended 500 g (and now 22 weeks) as the lower limits for reporting perinatal and infant mortality, Australia had already adopted legal and statistical definitions for birthweight (400 g) and gestational age (20 weeks) limits that were lower than the WHO limits. Also, the upper limit for the perinatal period in Australia was 28 days. These broader definitions in Australia obviously comply with, and extend, the WHO definitions.</p> <p>To avoid unnecessary confusion between legal and statistical definitions in Australia, for the purposes of perinatal data collection it is recommended that the perinatal period commences at 20 completed weeks (140 days) of gestation and ends 28 completed days after birth.</p>
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Perineal status

Identifying and Definitional Attributes

Knowledgebase ID: 000125 **Version No:** 2

Metadata type: Data Element

Admin. status: Current
01/07/01

Definition: State of the perineum following birth.

Context: Perinatal:
Perineal laceration (tear) may cause significant maternal morbidity in the postnatal period. Episiotomy is an indicator of management during labour and, to some extent, of intervention rates.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Intact
2	1st degree laceration/vaginal graze
3	2nd degree laceration
4	3rd degree laceration
5	Episiotomy
6	Combined laceration and episiotomy
7	4th degree laceration
8	Other
9	Not stated

Guide for use: Vaginal tear is included in the same group as 1st degree laceration to be consistent with ICD-10-AM code. Other degrees of laceration are as defined in ICD-10-AM.

Verification rules:

Collection methods:

Related metadata:

- is used in conjunction with Anaesthesia administered during labour vers 1
- is used in conjunction with Method of birth vers 1
- supersedes previous data element Perineal status vers 1
- is used in conjunction with Presentation at birth 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:

While 4th degree laceration is more severe than an episiotomy it has not been placed in order of clinical significance within the data domain. Instead it has been added to the data domain as a new code rather than modifying the existing order of data domain code values. This is because information gatherers are accustomed to the existing order of the codes. Modifying the existing order may result in miscoding of data. This approach is consistent with established practice in classifications wherein a new data domain identifier (or code number) is assigned to any new value meaning that occurs, rather than assigning this new value domain meaning to an existing data domain identifier.

Period of residence in Australia

Identifying and Definitional Attributes

Knowledgebase ID: 000126 **Version No:** 1

Metadata type: Data Element

Admin. status: Current
01/07/89

Definition: Length of time in years.

Context: This data item was included in the recommended second-level data set by the National Committee on Health and Vital Statistics (1979) to allow analyses relating to changes in morbidity patterns of ethnic subpopulations related to length of stay in host country; for example, cardiovascular disease among Greek immigrants in Australia.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NN

Minimum size: 2

Maximum size: 2

Data domain:

00	Under one year residence in Australia
01-97	1 to 97 years residence in Australia
98	Born in Australia
99	Unknown

Guide for use:

Verification rules:

Collection methods: This information may be obtained either from:

- a direct question with response values as specified in the data domain or
- derived from other questions about date of birth, birthplace and year of arrival in Australia.

Related metadata: is used in conjunction with Country of birth vers 3

Administrative Attributes

Source document:

Source organisation: National minimum data set working parties

Information model link:

NHIM Demographic characteristic

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

Comments: This item was not considered a high priority by the Office of Multicultural Affairs (1988) and to date only Country of birth and Indigenous status are considered by the National Health Data Committee to be justified for inclusion in the NMDS - Admitted patient care.

Peripheral neuropathy – status

Identifying and Definitional Attributes

<i>Knowledgebase ID:</i>	000839	<i>Version No:</i>	1
<i>Metadata type:</i>	Data Element		
<i>Admin. status:</i>	Current		
	01/01/03		
<i>Definition:</i>	The outcome of assessment for the presence of peripheral neuropathy.		
<i>Context:</i>	Public health, health care and clinical settings.		

Relational and Representational Attributes

<i>Datatype:</i>	Numeric
<i>Representational form:</i>	Code
<i>Representational layout:</i>	N
<i>Minimum size:</i>	1
<i>Maximum size:</i>	1

<i>Data domain:</i>	1	Yes, peripheral neuropathy is present
	2	No, peripheral neuropathy is not present
	9	Not stated/inadequately described

Guide for use: Record whether or not peripheral neuropathy is present determined by clinical judgement following assessment using pinprick and vibration (using perhaps a biothesiometer or monofilament).

Verification rules:

Collection methods: The preferred assessment methods are monofilament and biothesiometer. These two non-invasive tests provide more objective and repeatable results than testing sensation with pinprick or a tuning fork, which are very difficult to standardise.

Monofilament method

The 'Touch-Test' Sensory Evaluation (Semmens-Weinstein Monofilaments) application guidelines:

- Occlude the patient's vision by using a shield or by having the patient look away or close his or her eyes.
- Instruct the patient to respond when a stimulus is felt by saying 'touch' or 'yes'.
- Prepare to administer the stimulus to the foot (dorsal or plantar surface)
- Press the filament of the Touch.
- Test at a 90 degree angle against the skin until it bows. Hold in place for approximately 1.5 seconds and then remove.

To assure the validity of the sensory test findings:

- The patient must not be able to view the administration of the stimuli so that false indications are avoided.
- The nylon filament must be applied at a 90 degree angle against the skin until it bows for approximately 1.5 second before removing.
- If the patient does not feel the filament, then protective pain sensation has been lost.

Biesthesiometer method

Testing vibration sensation with a biothesiometer – application guidelines:

- The biothesiometer has readings from 0 to 50 volts. It can be made to vibrate at increasing intensity by turning a dial.
- A probe is applied to part of the foot, usually on the big toe.
- The person being tested indicates as soon as he/she can feel the vibration and the reading on the dial at that point is recorded.

The reading is low in young normal individuals (i.e. they are very sensitive to vibration). In older individuals, the biothesiometer reading becomes progressively higher. From experience, it is known that the risk of developing a neuropathic ulcer is much higher if a person has a biothesiometer reading greater than 30–40 volts.

Related metadata:

relates to the data element Health professionals attended – diabetes mellitus vers 1

relates to the data element Foot deformity vers 1

relates to the data element Foot lesion – active 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 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 Assessment event

Data Set Specifications:

DSS – Diabetes (clinical)

Start date **End date**

01/01/2003

Comments:

Peripheral neuropathy is a general term indicating peripheral nerve disorders of any cause. The most important aspect of grading diabetic neuropathy from a foot ulceration point of view is to assess the degree of loss of sensation in the feet.

Examine for neuropathy by testing reflexes and sensation preferably using tuning fork (standard vibration fork 128 hz), pinprick, 10 g monofilament and/or biothesiometer.

Diabetic neuropathy tends to occur in the setting of long-standing hyperglycaemia.

Peripheral neuropathy, which affects about 30% of people with either type 1 or type 2 diabetes, is the major predisposing disorder for diabetic foot disease. Peripheral neuropathy in feet results in loss of sensation and autonomic dysfunction. Neuropathy can occur either alone (neuropathic feet) or in combination with peripheral vascular disease causing ischaemia (neuro-ischaemic feet). Purely ischaemic feet are unusual, but are managed in the same way as neuro-ischaemic feet (see Australian Diabetes Society: Position Statement: The Lower Limb in People With Diabetes).

As stated by Duffy and others, the rate of lower extremity amputations can be reduced by 50% by the institution of monofilament testing in a preventive care program.

Diabetes polyneuropathy is frequently asymptomatic but may be associated with numbness, tingling and paraesthesia in the extremities, and less often with hyperesthesias. The most common form is a distal, symmetric, predominantly sensory polyneuropathy, which begins and is usually most marked in the feet and legs.

If symptomatic neuropathy is present consult with endocrinologist or physician specialising in diabetes care since options are available for the relief of symptoms.

Peripheral nerve function should be checked at least yearly in the patient with diabetes.

References:

1997 North Coast Medical, INC. San Jose, CA 95125; 800 821-9319.

Duffy MD, John C and Patout MD, Charles A. 1990. 'Management of the Insensitive Foot in Diabetes: Lessons from Hansen's Disease'. *Military Medicine*, 155: 575-579.

Bell-Krotovski OTR, FAOT, FAOTA, Judith and Elizabeth Tomancik LOTR. 1987. The Repeatability of testing with Semmens-Weinstein Monofilaments. 'The Journal of Hand Surgery,' 12A: 155 - 161.

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

Foot Examination - an interactive guide; *Aust Prescr* 2002; 25: 8-10.

Peripheral vascular disease in feet – status

Identifying and Definitional Attributes

Knowledgebase ID:	000840	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/01/03	
Definition:	The outcome of assessment for the presence of peripheral vascular disease in 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:	1	Yes, peripheral vascular disease is present in the feet
	2	No, peripheral vascular disease is not present in the feet
	9	Not stated/inadequately described

Guide for use: Record whether or not there is an absence of both dorsalis pedis and posterior tibial pulses in either foot.

Verification rules:

Collection methods: If it is mild, peripheral vascular disease can be completely without symptoms. However, compromised blood supply in the long term could cause claudication (pain in the calf after walking for a distance or up an incline or stairs), rest pain or vascular ulceration.

Physical examination is necessary to assess the peripheral vascular circulation. Purplish colour and cold temperature of feet are indications to suspect that the circulation may be impaired.

Palpate pulses:

The simplest method to estimate blood flow and to detect ischaemia to the lower extremities is palpation of the foot pulses (posterior tibial and dorsalis pedis arteries) in both feet. Note whether pulses are present or absent. If pulses in the foot can be clearly felt, the risk of foot ulceration due to vascular disease is small.

Test capillary return:

A helpful confirmation sign of arterial insufficiency is pallor of the involved feet after 1-2 min of elevation if venous filling time is delayed beyond the normal limit of 15 sec.

Doppler probe:

If pulses cannot be palpated, apply a small hand-held Doppler, placed over the dorsalis pedis or posterior tibial arteries to detect pulses, quantify the vascular supply and listen to the quality of the signal.

When the foot pulses are very weak or not palpable, the risk assessment could

be completed by measuring the ankle brachial index (ankle pressure/brachial pressure). Normal ankle brachial index is 0.9–1.2. An ankle brachial index less than 0.6 indicates compromised peripheral circulation.

Related metadata:

- relates to the data element Health professionals attended – diabetes mellitus vers 1
- relates to the data element Foot deformity vers 1
- relates to the data element Foot lesion – active 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

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:

Peripheral vascular disease is the leading cause of occlusion of blood vessels of the extremities with increasing prevalence in individuals with hypertension, hypercholesterolemia and diabetes mellitus, and in cigarette smokers. Peripheral vascular disease is estimated to occur 11 times more frequently and develop about 10 years earlier in people with diabetes.

Presence of symptomatic peripheral vascular disease requires an interdisciplinary approach including a vascular surgeon, an endocrinologist or physician specialising in diabetes care.

References:

Foot Examination – an interactive guide; Australian Prescriber

Person identifier

Identifying and Definitional Attributes

Knowledgebase ID:	000127	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/89	
Definition:	Person identifier unique within an establishment or agency.	
Context:	This item could be used for editing at the establishment or collection authority level and, potentially, for episode linkage. There is no intention that this item would be available beyond collection authority level.	

Relational and Representational Attributes

Datatype:	Alphanumeric
Representational form:	Identification number
Representational layout:	AN(20)
Minimum size:	6
Maximum size:	20
Data domain:	Valid person identification number.
Guide for use:	Individual establishments or collection authorities may use their own alphabetic, numeric or alphanumeric coding systems.
Verification rules:	Field cannot be blank.
Collection methods:	
Related metadata:	relates to the data element Establishment identifier vers 4 is qualified by Person identifier type – health care vers 1

Administrative Attributes

Source document:	AS5017 Health care client identification (with adaptation)
Source organisation:	National minimum data set working parties
Information model link:	

NHIM Recipient role

Data Set Specifications:	Start date	End date
NMDS – Admitted patient care	01/07/2000	
NMDS – Admitted patient mental health care	01/07/2000	
NMDS – Perinatal	01/07/1997	
NMDS – Community mental health care	01/07/2000	
NMDS – Admitted patient palliative care	01/07/2000	
NMDS – Alcohol and other drug treatment services	01/07/2000	
NMDS – Non-admitted patient emergency department care	01/07/2003	
DSS – Cardiovascular disease (clinical)	01/01/2003	
DSS – Health care client identification	01/01/2003	

Comments:

Person identifier type – health care

Identifying and Definitional Attributes

Knowledgebase ID:	000841	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/01/03		
Definition:	A code based on the geographical or administrative breadth of applicability of Person identifier.		
Context:			

Relational and Representational Attributes

Datatype:	Alphabetic
Representational form:	Code
Representational layout:	A
Minimum size:	1
Maximum size:	1

Data domain:	A	Area/region/district
	L	Local
	S	State or Territory

Guide for use:	Code L: is for an identifier that is applicable only inside the issuing health care establishment
	Code A: is for an identifier that is applicable to: <ul style="list-style-type: none"> - all the Area/region/district health care services but not across all services in the State or Territory - all of a specific health care service (e.g. Community mental health) in an Area/region/district health care services but not across all those services in the State or Territory
	Code S: is for identifiers that are applicable across all State or Territory health care services.
	A person can have more than one Person identifier. Each Person identifier must have an appropriate Person identifier type code recorded.
	Use this field to record only Person identifier type. It must not be used to record any other person-related information.

Verification rules:

Collection methods:

Related metadata: is a qualifier of Person identifier vers 1

Administrative Attributes

Source document: AS5017 Health care client identification

Source organisation: Standards Australia

Information model link:

NHIM Recipient role

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

Comments:

Physical activity sufficiency status

Identifying and Definitional Attributes

Knowledgebase ID:	000672	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/01/03	
Definition:	Sufficiency of moderate or vigorous physical activity to confer a health benefit.	
Context:	Public health, health care and clinical setting: To monitor health risk factors for national health priority areas and other chronic diseases.	

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>Sufficient</td> </tr> <tr> <td>2</td> <td>Insufficient</td> </tr> <tr> <td>3</td> <td>Sedentary</td> </tr> <tr> <td>9</td> <td>Not stated/inadequately described</td> </tr> </table>	1	Sufficient	2	Insufficient	3	Sedentary	9	Not stated/inadequately described
1	Sufficient								
2	Insufficient								
3	Sedentary								
9	Not stated/inadequately described								

Guide for use:	<p>The clinician makes a judgment based on assessment of the person's reported physical activity history for a usual 7-day period where:</p> <p>Code 1: Sufficient physical activity for health benefit for a usual 7-day period is calculated by summing the total minutes of walking, moderate and/or vigorous physical activity.</p> <p>Vigorous physical activity is weighted by a factor of two to account for its greater intensity. Total minutes for health benefit need to be equal to or more than 150 minutes per week.</p> <p>Code 2: Insufficient physical activity for health benefit is where the sum of the total minutes of walking, moderate and/or vigorous physical activity for a usual 7-day period is less than 150 minutes but more than 0 minutes.</p> <p>Code 3: Sedentary is where there has been no moderate and/or vigorous physical activity during a usual 7-day period.</p> <p>Code 9: There is insufficient information to more accurately define the person's physical activity sufficiency status or the information is not known.</p> <p>Note: The National Heart Foundation of Australia and the National Physical Activity Guidelines for Australians describes moderate-intensity physical activity as causing a slight but noticeable, increase in breathing and heart rate and suggests that the person should be able to comfortably talk but not sing. Examples of moderate physical activity include brisk walking, low pace swimming, light to moderate intensity exercise classes. Vigorous physical activity is described as activity, which causes the person to 'huff and puff', and where talking in a full sentence between breaths is difficult.</p> <p>Examples of vigorous physical activity include jogging, swimming (freestyle) and singles tennis.</p>
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Verification rules:**Collection methods:**

Related metadata: relates to the data element Behaviour-related risk factor intervention vers 1 is used in conjunction with Service contact date vers 1

Administrative Attributes

Source document: The National Heart Foundation of Australia's Physical Activity Policy, April 2001.

National Physical Activity Guidelines For Australians, developed by the University of Western Australia & the Centre for Health Promotion and Research, Sydney, for the Commonwealth Department of Health and Ageing.

Source organisation: CV-Data Working Group

Information model link:

NHIM Lifestyle characteristic

Data Set Specifications:

DSS - Cardiovascular disease (clinical)

Start date

End date

01/01/2003

Comments:

The above grouping subdivides a population into three mutually exclusive categories.

A sufficiently physically active person is a person who is physically active on a regular weekly basis equal to or in excess of that required for a health benefit. Sufficient physical activity for health results from participation in physical activity of adequate duration and intensity. Although there is no clear absolute threshold for health benefit, the accrual of 150 minutes of moderate (at least) intensity physical activity over a period of one week is thought to confer health benefit. Walking is included as a moderate intensity physical activity. Note that the 150 minutes of moderate physical activity should be made up of 30 minutes on most days of the week and this can be accumulated in 10 minute bouts (National Physical Activity Guidelines for Australians).

Health benefits can also be obtained by participation in vigorous physical activity, in approximate proportion to the total amount of activity performed, measured either as energy expenditure or minutes of physical activity (Pate et al. 1995).

Physical activity - health benefit for vigorous physical activity is calculated by:

- incorporating a weighted factor of 2, to account for its greater intensity
- summing the total minutes of walking, moderate and/or vigorous physical activity will then give an indication if a health benefit is likely.

Insufficient physical activity describes a person who engages in regular weekly physical activity but not to the level required for a health benefit through either moderate or vigorous physical activity.

A sedentary person is a person who does not engage in any regular weekly physical activity.

Place of occurrence of external cause of injury

Identifying and Definitional Attributes

Knowledgebase ID:	000384	Version No: 5
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/00	
Definition:	The place where the external cause of injury, poisoning or adverse effect occurred.	
Context:	Enables categorisation of injury and poisoning according to factors important for injury control. Necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research.	

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	N(N)
Minimum size:	1
Maximum size:	2
Data domain:	<ul style="list-style-type: none"> 0 Home 1 Residential institution 2 School, other institution and public administration area 21 School 22 Health service area 23 Building used by general public or public group 3 Sports and athletics area 4 Street and highway 5 Trade and service area 6 Industrial and construction area 7 Farm 8 Other specified places 9 Unspecified place

Guide for use:	<p>Admitted patients:</p> <p>Use the appropriate codes as fourth and fifth characters to Y92 when using the ICD-10-AM 3rd edition. Used with all ICD-10-AM external cause codes V01-Y89 and assigned according to the Australian Coding Standards.</p> <p>Non-admitted patients:</p> <p>to be used for injury surveillance purposes for non-admitted patients when it is not possible to use ICD-10-AM codes. Select the code which best characterises the type of place where the person was situated when the injury occurred on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one that comes first in the code list.</p>
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Verification rules:	Admitted patients: to be used with ICD-10-AM external cause codes V01-Y89.
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Collection methods:**Related metadata:**

relates to the data element Diagnosis onset type vers 1
 is used in conjunction with External cause – admitted patient vers 4
 is used in conjunction with External cause – non-admitted patient vers 4
 supersedes previous data element Place of occurrence of external cause of injury – admitted patient vers 4
 supersedes previous data element Place of occurrence of external cause of injury – non-admitted patient vers 3

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

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

Information model link:

NHIM Other setting

Data Set Specifications:

	<i>Start date</i>	<i>End date</i>
NMDS – Admitted patient care	01/07/2000	
NMDS – Injury surveillance	01/07/2000	

Comments:

This data item has been modified to recognise the use of this information in injury surveillance. There has been no change to the coding requirements for patients admitted to hospital. The addition of an extended classification has been necessary to cater for the information requirements of the wide range of settings undertaking injury surveillance.

Place of occurrence for injury surveillance (type of place) has been extended to improve the identification of some important places where injuries occur. This also enables linking of the classification with ICD-10. Use of the number '0' has been avoided to ensure there are fewer problems with the data collection. This item will be reviewed when ICD-10 is adopted.

Further information on the national injury surveillance program may be obtained from the National Injury Surveillance Unit, Australian Institute of Health and Welfare, Adelaide. The recommended classification for injury surveillance purposes is as follows:

Injury surveillance – type of place:

- 1 Home (includes farm house)
- 2 Residential institution (excludes hospital – code 4)
- 3 School, other institutional or public administrative area
- 4 Hospital or other health service
- 5 Place of recreation (mainly for informal recreational activities)
- 6 Sports and athletics area (mainly for formal sports etc.)
- 7 Street or highway
- 8 Trade or service area
- 9 Industrial or construction area
- 10 Mine or quarry
- 11 Farm (excludes farm house – code 1)
- 12 Other specified places
- 13 Unspecified place

Postal delivery point identifier

Identifying and Definitional Attributes

Knowledgebase ID:	000789	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/01/03	
Definition:	A unique number assigned to a postal address as recorded on the Australia Post Postal Address File (PAF).	

Context:

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	N(8)
Minimum size:	0
Maximum size:	8

Data domain: Valid Delivery Point Identifier (DPID) Code or blank

Guide for use: Australia Post maintains a PAF database which contains Australian postal delivery addresses and their corresponding eight (8) character unique identification number known as a delivery point identifier (DPID). While the PAF is concerned with postal address, many persons' postal address will be the same as their residential address. The PAF can be used to improve the recording of address data at the time of data entry.

The PAF may be used at the time of data entry to confirm that the combined data elements of Suburb/town/locality, State/Territory Identifier and Postcode are accurately recorded.

Verification rules: Field may be blank (where the person's address is not a recognised Australia Post delivery address).

Collection methods: The DPID is assigned electronically to recognised Australia Post delivery addresses following reference to the PAF database.

Related metadata:

- relates to the data element Address type vers 1
- relates to the data element Australian postcode vers 1
- relates to the data element State/Territory identifier vers 3
- relates to the data element Suburb/town/locality vers 1

Administrative Attributes

Source document: AS5017 Health care client identification

Source organisation: Standards Australia

Information model link:
NHIM Address element

Data Set Specifications:

DSS - Health care client identification

Start date

01/01/2003

End date**Comments:**

In October 1999, Australia Post introduced a bar-coding system for bulk mail lodgements. Health care establishments can use software to improve the quality of person address data it collects and records and, at the same time, receive financial benefits by reducing its postage expenses.

The DPID is easily converted to a bar code and can be included on correspondence and address labels. If the bar code is displayed on a standard envelope that passes through a mail-franking machine (used by most major hospitals), the postage cost is reduced.

Every three months, Australia Post provides updates to the PAF database. For more information, contact Australia Post.

Postpartum complication

Identifying and Definitional Attributes

Knowledgebase ID:	000131	Version No: 2
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/98	
Definition:	Medical and obstetric complications of the mother occurring during the postnatal period up to the time of separation from care.	
Context:	Perinatal statistics: Complications of the puerperal period may cause maternal morbidity, and occasionally death, and may be an important factor in prolonging the duration of hospitalisation after childbirth.	

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
Guide for use:	There is no arbitrary limit on the number of conditions specified.
Verification rules:	Complications should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM
Collection methods:	
Related metadata:	is used in conjunction with Complication of labour and delivery vers 2

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 Perinatal Data Development Committee		
Information model link:	NHIM Physical wellbeing		
Data Set Specifications:	Start date	End date	
Comments:	Examples of such conditions include postpartum haemorrhage, retained placenta, puerperal infections, puerperal psychosis, essential hypertension, psychiatric disorders, diabetes mellitus, epilepsy, cardiac disease and chronic renal disease.		

Preferred language

Identifying and Definitional Attributes

Knowledgebase ID: 000132 **Version No:** 2

Metadata type: Data Element

Admin. status: Current
01/07/98

Definition: The language (including sign language) most preferred by the person for communication. This may be a language other than English even where the person can speak fluent English.

Context: Health and welfare services:
An important indicator of ethnicity, especially for persons born in non-English-speaking countries. Its collection will assist in the planning and provision of multilingual services and facilitate program and service delivery for migrants and other non-English speakers.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NN

Minimum size: 2

Maximum size: 2

Data domain:

00	Afrikaans
01	Albanian
02	Alyawarr (Alyawarra)
03	Arabic (including Lebanese)
04	Armenian
05	Arrernte (Aranda)
06	Assyrian (including Aramaic)
07	Australian Indigenous languages, not elsewhere classified
08	Bengali
09	Bisaya
10	Bosnian
11	Bulgarian
12	Burarra
13	Burmese
14	Cantonese
15	Cebuano
16	Croatian
17	Czech
18	Danish
19	English
20	Estonian
21	Fijian

22	Finnish
23	French
24	German
25	Gilbertese
26	Greek
27	Gujarati
28	Hakka
29	Hebrew
30	Hindi
31	Hmong
32	Hokkien
33	Hungarian
34	Indonesian
35	Irish
36	Italian
37	Japanese
38	Kannada
39	Khmer
40	Korean
41	Kriol
42	Kuurinji (Gurindji)
43	Lao
44	Latvian
45	Lithuanian
46	Macedonian
47	Malay
48	Maltese
49	Mandarin
50	Mauritian Creole
51	Netherlandic
52	Norwegian
53	Persian
54	Pintupi
55	Pitjantjatjara
56	Polish
57	Portuguese
58	Punjabi
59	Romanian
60	Russian
61	Samoan
62	Serbian
63	Sinhalese
64	Slovak
65	Slovene
66	Somali
67	Spanish

68	Swahili
69	Swedish
70	Tagalog (Filipino)
71	Tamil
72	Telugu
73	Teochew
74	Thai
75	Timorese
76	Tiwi
77	Tongan
78	Turkish
79	Ukranian
80	Urdu
81	Vietnamese
82	Walmajarri (Walmadjari)
83	Warlpiri
84	Welsh
85	Wik-Mungkan
86	Yiddish
95	Other languages, not further defined
96	Inadequately described
97	Non-verbal, so described (including sign languages e.g. Auslan, Makaton)
99	Not stated

Guide for use:

The classification used in this data element is a modified 2-digit level version of the Australian Bureau of Statistics' (ABS) classification: Australian Standard Classification of Languages (ASCL).

All non-verbal means of communication, including sign languages, are to be coded to 97.

Code 96 should be used where some information, but insufficient, is provided.

Code 98 is to be used when no information is provided.

All Australian indigenous languages not shown separately on the code list are to be coded to 07.

Verification rules:**Collection methods:**

This information may be collected in a variety of ways. It may be collected by using a predetermined shortlist of languages that are most likely to be encountered from the above code list accompanied by an open text field for Other language or by using an open ended question that allows for recording of the language nominated by the person. Regardless of the method used for data collection the language nominated should be coded using the above ABS codes.

Related metadata:

supersedes previous data element Preferred language vers 1

Administrative Attributes**Source document:**

Australian Standard Classification of Languages, Australian Bureau of Statistics, Catalogue No. 1267.0

Source organisation: National Health Data Committee
Australian Bureau of Statistics

Information model link:

NHIM Social characteristic

Data Set Specifications:	Start date	End date
NMDS - Alcohol and other drug treatment services	01/07/2002	
DSS - Cardiovascular disease (clinical)	01/01/2003	

Comments:

The ABS has developed a detailed 4-digit language classification of 193 language units which was used in the 1996 Census. Although it is preferable to use the classification at a 4-digit level, the requirements of administrative collections have been recognised and the ABS has developed a classification of 86 languages at a 2-digit level from those most frequently spoken in Australia. Mapping of this 2-digit running code system to the 4-digit ASCL is available from ABS. The classification used in this data element is a modified version of the 2-digit level ABS classification. The National Health Data Committee considered that the grouping of languages by geographic region was not useful in administrative settings. Thus the data domain includes an alphabetical listing of the 86 languages from the ABS 2-digit level classification with only one code for Other languages, not further defined. By removing the geographic groupings from the classification information about the broad geographic region of languages that are not specifically coded is lost. However, the NHDC considered that the benefits to data collectors gained from simplifying the code listing outweighed this disadvantage.

Pregnancy – current status

Identifying and Definitional Attributes

Knowledgebase ID:	000842	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/01/03	
Definition:	Whether a female person is currently pregnant.	
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 pregnant</td> </tr> <tr> <td>2</td> <td>No, not currently pregnant</td> </tr> <tr> <td>9</td> <td>Not stated/inadequately described</td> </tr> </table>	1	Yes, currently pregnant	2	No, not currently pregnant	9	Not stated/inadequately described
1	Yes, currently pregnant						
2	No, not currently pregnant						
9	Not stated/inadequately described						
Guide for use:	Record whether or not the female individual is currently pregnant						
Verification rules:							
Collection methods:	Ask the individual if she is currently pregnant.						
Related metadata:	relates to the data element Diabetes 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:	Pregnancy in women with pre-existing diabetes is a potentially serious problem for both the mother and foetus. Good metabolic control and appropriate medical and obstetric management will improve maternal and foetal outcomes. The diagnosis or discovery of diabetes in pregnancy (gestational diabetes), identifies an at risk pregnancy from the foetal perspective, and identifies the mother as at risk for the development of type 2 diabetes later in life.	

Following Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus diabetes management during pregnancy includes:

- routine medical review every 2-3 weeks during the first 30 weeks and then every 1-2 weeks until delivery
- monitor HbA1c every 4-6 weeks or more frequently if indicated to ensure optimal metabolic control during pregnancy
- advise patients to monitor blood glucose frequently and urinary ketones
- initial assessment and on going monitoring for signs or progression of diabetes complications
- regular routine obstetric review based on the usual indicators.

Management targets:

- blood glucose levels:
 - Fasting < 5.5 mmol/L
 - Post-prandial < 8.0 mmol/L at 1 hour, < 7mmol/L at 2 hours
- HbA1c levels within normal range for pregnancy. (The reference range for HbA1c will be lower during pregnancy)
- the absence of any serious or sustained ketonuria.

Normal indices for foetal and maternal welfare. Oral hypoglycaemic agents are contra-indicated during pregnancy and therefore women with pre-existing diabetes who are treated with oral agents should ideally be converted to insulin prior to conception.

What to do if unsatisfactory metabolic control:

- Explore reasons for unsatisfactory control such as diet, intercurrent illness, appropriateness of medication, concurrent medication, stress, and exercise, and review management.
- Review and adjust treatment.
- Consider referral to diabetes educator, dietitian, endocrinologist or physician experienced in diabetes care, or diabetes centre.

Premature cardiovascular disease family history – status

Identifying and Definitional Attributes

Knowledgebase ID:	000659	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/01/03	
Definition:	Identifies a person who has a first degree relative (father, mother or sibling) who has had a vascular event or condition diagnosed before the age of 60 years.	
Context:	Public health, health care and clinical settings.	

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</td> </tr> <tr> <td>2</td> <td>No</td> </tr> <tr> <td>3</td> <td>Family history status not known</td> </tr> <tr> <td>9</td> <td>Not recorded</td> </tr> </table>	1	Yes	2	No	3	Family history status not known	9	Not recorded
1	Yes								
2	No								
3	Family history status not known								
9	Not recorded								

Guide for use:	Code 1: Yes, the person has a first-degree relative under the age of 60 years who has had a vascular disease/condition diagnosed.
	Code 2: No, the person does not have a first-degree relative under the age of 60 years who has had a vascular disease/condition diagnosed.
	Code 3: Family history status not known, the existence of a premature family history for cardiovascular disease cannot be determined.
	Code 9: Not recorded, the information as to the existence of a premature family history for cardiovascular disease has not been recorded.

Verification rules:

Collection methods:

Related metadata:

Administrative Attributes

Source document:	Guidelines Subcommittee of the WHO-ISH: 1999 WHO-ISH guidelines for management of hypertension. J Hypertension 1999; 17: 151–83.		
Source organisation:	CV-Data Working Group		
Information model link:	NHIM Physical wellbeing		
Data Set Specifications:	Start date	End date	
DSS – Cardiovascular disease (clinical)	01/01/2003		

Comments:

DSS - Cardiovascular disease (clinical):

Having a family history of cardiovascular disease (CVD) is a risk factor for CVD and the risk increases if the event in the family member occurs at a young age. For vascular risk assessment a premature family history is considered to be present where a first-degree relative under age 60 years (woman or man) has had a vascular event/condition diagnosed. The evidence of family history being a strong risk factor for stroke only applies to certain limited stroke subtypes in certain populations.

Presentation at birth

Identifying and Definitional Attributes

Knowledgebase ID:	000133	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/96	
Definition:	Presenting part of the foetus (at lower segment of uterus) at birth.	
Context:	Perinatal statistics: Presentation types other than vertex are associated with higher rates of caesarean section, instrumental delivery, perinatal mortality and neonatal morbidity.	

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>Vertex</td> </tr> <tr> <td>2</td> <td>Breech</td> </tr> <tr> <td>3</td> <td>Face</td> </tr> <tr> <td>4</td> <td>Brow</td> </tr> <tr> <td>8</td> <td>Other</td> </tr> <tr> <td>9</td> <td>Not stated</td> </tr> </table>	1	Vertex	2	Breech	3	Face	4	Brow	8	Other	9	Not stated
1	Vertex												
2	Breech												
3	Face												
4	Brow												
8	Other												
9	Not stated												

Guide for use:

Verification rules:

Collection methods:

Related metadata: is used in conjunction with Method of birth vers 1

Administrative Attributes

Source document:

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Birth event

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

Comments:

Previous pregnancies

Identifying and Definitional Attributes

Knowledgebase ID:	000134	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/96	
Definition:	The total number of previous pregnancies, specified as pregnancies resulting in: <ul style="list-style-type: none"> - live birth - stillbirth - at least 20 weeks' gestational age or 400 g birthweight - spontaneous abortion (less than 20 weeks' gestational age, or less than 400 g birthweight if gestational age is unknown) - induced abortion (termination of pregnancy before 20 weeks' gestation) - ectopic pregnancy. 	

Context:	Perinatal statistics: The number of previous pregnancies is an important component of the woman's reproductive history. Parity may be a risk factor for adverse maternal and perinatal outcomes. A previous history of stillbirth or spontaneous abortion identifies the mother as high risk for subsequent pregnancies. A previous history of induced abortion may increase the risk of some outcomes in subsequent pregnancies.
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Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	NN
Minimum size:	2
Maximum size:	2

Data domain:	2-digit numeric field representing the number of pregnancies for each of the categories above, or 99 for not stated
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Guide for use:	A pregnancy resulting in multiple births should be counted as one pregnancy. In multiple pregnancies with more than one type of outcome, the pregnancies should be recorded in the following order: <ul style="list-style-type: none"> - all live births - stillbirth - spontaneous abortion - induced abortion - ectopic pregnancy
-----------------------	--

Where the outcome was one stillbirth and one live birth, count as stillbirth.

Verification rules:

Collection methods:

Related metadata: is qualified by Date of completion of last previous pregnancy vers 1
is used in conjunction with Outcome of last previous pregnancy 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:

Previous specialised treatment

Identifying and Definitional Attributes

Knowledgebase ID:	000139	Version No: 3
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/99	
Definition:	Whether a patient has had a previous admission or service contact for treatment in the specialty area within which treatment is now being provided.	

Context:

Relational and Representational Attributes

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

Data domain:	1	Patient has no previous admission(s) or service contact(s) for the specialised treatment now being provided
	2	Patient has previous hospital admission(s) but no service contact(s) for the specialised treatment now being provided
	3	Patient has previous service contact(s) but no hospital admission(s) for the specialised treatment now being provided
	4	Patient has both previous hospital admission(s) and service contact(s) for the specialised treatment now being provided
	5	Unknown/not stated

Guide for use:	Codes 2-4: Includes patients who have been seen at any time in the past within the specialty within which the patient is currently being treated (mental health or palliative care), regardless of whether it was part of the current episode or a previous admission/service contact many years in the past. Use these codes regardless of whether the previous treatment was provided within the service in which the person is now being treated, or another equivalent specialised service (either institutional or community-based). Admitted patients, whose only prior specialised treatment contact was the service contact that referred the patient for admission should be coded as 1.
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Verification rules:

Collection methods:

Related metadata:	supersedes previous data element First admission for psychiatric treatment vers 2
	relates to the data element concept Service contact vers 1

Administrative Attributes

Source document:

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

Information model link:

NHIM Request for/entry into service event

Data Set Specifications:

NMDS - Admitted patient mental health care

Start date**End date**

01/07/1999

NMDS - Admitted patient palliative care

01/07/2000

Comments:

This data item was originally developed in the context of mental health institutional care data development (originally the data element Problem status and later First admission for psychiatric treatment). More recent data development work, particularly in the area of palliative care, led to the need for this data item to be re-worded in more generic terms for inclusion in other data sets.

For palliative care, the value of this data element is in its use in enabling approximate identification of the number of new palliative care patients receiving specialised treatment. The use of this data element in this way would be improved by the reporting of this data by community-based services.

Primary site of cancer

Identifying and Definitional Attributes

Knowledgebase ID: 000776

Version No: 1

Metadata type: Data Element

Admin. status: Current

01/07/02

Definition: The primary site is the site of origin of the tumour, as opposed to the secondary or metastatic sites. It is described by reporting the anatomical position (topography) of the tumour.

Context: This information is collected for the purpose of:

- classifying tumours into clinically-relevant groupings on the basis of both their site of origin and their histological type
- monitoring the number of new cases of cancer for planning treatment services
- epidemiological studies.

Relational and Representational Attributes

Datatype: Alphanumeric

Representational form: Code

Representational layout: ANNNN

Minimum size: 3

Maximum size: 5

Data domain: Cancer registries:

The current version of International Classification of Diseases for Oncology

Hospitals:

ICD-10-AM 3rd edition

Guide for use:

Report the primary site of cancer, if known, for patients who have been diagnosed with a cancer. In ICD-10-AM, primary site is identified using a single 4-digit code Cxx.x or Dxx.x. In ICDO, primary site is identified using both the Cxx.x code

Identifying site and the behaviour code to identify whether the site is the primary site. The behaviour code numbers used in ICDO are listed below:

- | | |
|---|---|
| 0 | Benign |
| 1 | Uncertain whether benign or malignant |
| | - borderline malignancy |
| | - low malignant potential |
| 2 | Carcinoma in situ |
| | - intraepithelial |
| | - non-infiltrating |
| | - non-invasive |
| 3 | Malignant, primary site |
| 6 | Malignant, metastatic site |
| | - malignant, secondary site |
| 9 | Malignant, uncertain whether primary or metastatic site |

Verification rules:**Collection methods:**

Cancer registries use Site codes from the current version of ICDO.

In a hospital setting, primary site of cancer should be recorded on the patient's medical record by the patient's attending clinician or medical practitioner, and coded by the hospital's medical records department.

Hospitals use Diagnosis codes from ICD-10-AM. Valid codes must start with C or D.

In hospital reporting, the diagnosis code for each separate primary site cancer will be reported as a 'Principal Diagnosis' or an 'Additional Diagnosis' as defined in the current edition of the Australian Coding Standards. In death reporting, the Australian Bureau of Statistics uses ICD-10.

Some ICD-10-AM diagnosis codes e.g. mesothelioma and Kaposi's sarcoma, are based on morphology and not site alone, and include tumours of these types even where the primary site is unknown.

Related metadata:

is a qualifier of Laterality of primary cancer vers 1

Administrative Attributes**Source document:**

International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10).

International Classification of Diseases for Oncology, Second Edition (ICDO-2).

International Classification of Diseases Tenth Revision, Australian Modification (3rd edition 2002), National Centre for Classification in Health, Sydney (ICD-10-AM).

Source organisation:

World Health Organization.

Information model link:

NHIM Assessment event

Data Set Specifications:

Start date

End date

Comments:

Principal area of clinical practice

Identifying and Definitional Attributes

Knowledgebase ID: 000135 **Version No:** 1

Metadata type: Data Element

Admin. status: Current
01/07/95

Definition: Principal area of clinical practice is defined as either the field of principal professional clinical activity or the primary area of responsibility, depending on the profession. It may be described in terms of the particular discipline, skills or knowledge field of the profession, whether general or specialised; or described in terms of the principal client group; or described by the principal activity of an institution, or section of an institution, where clinical practice takes place.

Context: Health labour force:
To analyse distribution of clinical service providers by the area of their principal clinical practice. Cross-classified with other data, this item allows analysis of geographic distribution and profiles of population subsets. Required for health labour force modelling.

Relational and Representational Attributes

Datatype: Alphanumeric

Representational form: Code

Representational layout: ANN

Minimum size: 3

Maximum size: 3

Data domain:

- A11 GP/primary medical care practitioner – general practice
- A12 GP/primary medical care practitioner – a special interest area (specified)
- A21 GP/primary medical care practitioner – vocationally registered
- A22 GP/primary medical care practitioner – holder of fellowship of RACGP
- A23 GP/primary medical care practitioner – RACGP trainee
- A24 GP/primary medical care practitioner – other
- B31 Non-specialist hospital (salaried) – RMO/intern
- B32 Non-specialist hospital (salaried) – other hospital career
- B41 Non-specialist hospital (salaried) – holder of Certificate of Satisfactory Completion of Training
- B42 Non-specialist hospital (salaried) – RACGP trainee
- B44 Non-specialist hospital (salaried) – other
- B51 Non-specialist hospital (salaried) – specialist (includes private and hospital)
- B52 Non-specialist hospital (salaried) – specialist in training (e.g. registrar)
- B90 Non-specialist hospital (salaried) – not applicable
- C The following nursing codes are subject to revision because of changes in the profession and should be read in the context of the comments below:
- C01 Nurse labour force – mixed medical/surgical nursing
- C02 Nurse labour force – medical nursing

- C03 Nurse labour force – surgical nursing
- C04 Nurse labour force – operating theatre nursing
- C05 Nurse labour force – intensive care nursing
- C06 Nurse labour force – paediatric nursing
- C07 Nurse labour force – maternity and obstetric nursing
- C08 Nurse labour force – psychiatric/mental health nursing
- C09 Nurse labour force – developmental disability nursing
- C10 Nurse labour force – gerontology/geriatric nursing
- C11 Nurse labour force – accident and emergency nursing
- C12 Nurse labour force – community health nursing
- C13 Nurse labour force – child health nursing
- C14 Nurse labour force – school nursing
- C15 Nurse labour force – district/domiciliary nursing
- C16 Nurse labour force – occupational health nursing
- C17 Nurse labour force – private medical practice nursing
- C18 Nurse labour force – independent practice
- C19 Nurse labour force – independent midwifery practice
- C20 Nurse labour force – no one principal area of practice
- C98 Nurse labour force – other (specify)
- C99 Nurse labour force – unknown/inadequately described/not stated

Guide for use:

Specifics will vary for each profession as appropriate and will be reflected in the classification/coding that is applied. Classification within the National Health Labour Force Collection is profession-specific.

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

Source organisation: National Health Labour Force Data Working Group

Information model link:

NHIM Labour characteristic

Data Set Specifications:

NMDS – Health labour force

Start date

End date

01/07/1995

Comments:

The comments that follow apply to the nurse labour force specifically.

It is strongly recommended that, in the case of the nurse labour force, further disaggregation be avoided as much as possible. The reason for this recommendation is that any expansion of the classification to include specific specialty areas (e.g. cardiology, otorhinolaryngology, gynaecology etc.) will only capture data from hospitals with dedicated wards or units; persons whose clinical practice includes a mix of cases within a single ward setting (as in the majority of country and minor metropolitan hospitals) will not be included in any single specialty count, leading to a risk of the data being misinterpreted. The data would show a far lower number of practitioners involved in providing services to patients with some of the listed specialty conditions than is the case.

Principal diagnosis

Identifying and Definitional Attributes

Knowledgebase ID:	000136	Version No: 3
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/98	
Definition:	The diagnosis established after study to be chiefly responsible for occasioning the patient's episode of care in hospital (or attendance at the health care facility).	
Context:	Health services:	
	The principal diagnosis is one of the most valuable health data elements. It is used for epidemiological research, casemix studies and planning purposes.	
	Admitted patients:	
	The principal diagnosis is a major determinant in the classification of Australian refined diagnosis related groups and Major diagnostic categories.	

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)
Guide for use:	<p>The principal diagnosis must be determined in accordance with the Australian Coding Standards. Each episode of admitted patient care must have a principal diagnosis and may have additional diagnoses. The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status. The first edition of ICD-10-AM, the Australian modification of ICD-10, was published by the National Centre for Classification in Health in 1998 and implemented from July 1998. The second edition was published for use from July 2000 and the third edition for use from July 2002.</p> <p>For the NMDS for Community Mental Health Care, codes can be used from ICD-10-AM or from The ICD-10-AM Mental Health Manual: An Integrated Classification and Diagnostic Tool for Community-Based Mental Health Services, published by the National Centre for Classification in Health in 2002.</p>
Verification rules:	<p>As a minimum requirement the Principal diagnosis code must be a valid code from ICD-10-AM (3rd edition).</p> <p>Some diagnosis codes are too imprecise or inappropriate to be acceptable as a principal diagnosis and will group to 951Z, 955Z and 956Z in the Australian refined diagnosis related groups, Version 4. A list of these diagnosis codes is available from the Acute and Coordinated Care Branch, Health Services Division, Department of Health and Ageing.</p> <p>Diagnosis codes starting with a V, W, X or Y, describing the circumstances that cause an injury, rather than the nature of the injury, cannot be used as principal diagnosis. Diagnosis codes which are morphology codes, cannot be used as principal diagnosis.</p>

Collection methods: A principal diagnosis should be recorded and coded upon separation, for each episode of patient care. The principal diagnosis is derived from and must be substantiated by clinical documentation.

Admitted patients:

Where the principal diagnosis is recorded prior to discharge (as in the annual census of public psychiatric hospital patients), it is the current provisional principal diagnosis. Only use the admission diagnosis when no other diagnostic information is available. The current provisional diagnosis may be the same as the admission diagnosis.

Related metadata:

- relates to the data element Additional diagnosis vers 4
- is an alternative to Bodily location of main injury vers 1
- relates to the data element Diagnosis onset type vers 1
- relates to the data element Diagnosis related group vers 1
- relates to the data element External cause – admitted patient vers 4
- relates to the data element External cause – human intent vers 4
- relates to the data element External cause – non-admitted patient vers 4
- is used in the derivation of Major diagnostic category vers 1
- is used as an alternative to Nature of main injury – non-admitted patient vers 1
- supersedes previous data element Principal diagnosis – ICD-9-CM code vers 2
- relates to the data element Procedure vers 5

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 Standard for Injury Surveillance Advisory Group

Information model link:

NHIM Physical wellbeing

Data Set Specifications:	Start date	End date
NMDS – Admitted patient care	01/07/1989	
NMDS – Admitted patient mental health care	01/07/1997	
NMDS – Community mental health care	01/07/2000	
NMDS – Admitted patient palliative care	01/07/2000	

Comments:

Principal drug of concern

Identifying and Definitional Attributes

Knowledgebase ID:	000443	Version No: 2
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/03	
Definition:	The main drug, as stated by the client, that has led a person to seek treatment from the service.	
Context:	Alcohol and other drug treatment services: Required as an indicator of the client's treatment needs.	

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	NNNN
Minimum size:	4
Maximum size:	4
Data domain:	Value found in the <i>Australian Standard Classification of Drugs of Concern</i>
Guide for use:	The principal drug of concern should be the main drug of concern to the client and is the focus of the client's treatment episode. If the client has been referred into treatment and does not nominate a drug of concern, then the drug involved in the client's referral should be chosen.
Verification rules:	
Collection methods:	To be collected on commencement of the treatment episode. For clients whose treatment episode is related to the alcohol and other drug use of another person, this data element should not be collected.
Related metadata:	is qualified by Client type - alcohol and other drug treatment services vers 3 relates to the data element Main treatment type for alcohol and other drugs vers 1 relates to the data element Method of use for principal drug of concern vers 1 relates to the data element Other drug of concern vers 2 relates to the data element Other treatment type for alcohol and other drugs vers 1 supersedes previous data element Principal drug of concern vers 1

Administrative Attributes

Source document:	The Australian Standard Classification of Drugs of Concern (ASCDC), Australian Bureau of Statistics Cat. No. 1248.0 (2000).
Source organisation:	Intergovernmental Committee on Drugs NMDS WG
Information model link:	NHIM Lifestyle characteristic

Data Set Specifications:

NMDS - Alcohol and other drug treatment services

Start date

01/07/2003

End date

Comments:

Principal role of health professional

Identifying and Definitional Attributes

Knowledgebase ID:	000138	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/95	
Definition:	The principal role of a health professional is that in which the person usually works the most hours each week.	
Context:	Health labour force: This data element provides information on the principal professional role of respondents who currently work within the broad context/discipline field of their profession (as determined by data element Professional labour force status). Identification of clinicians provides comparability with other labour force collections that just include clinicians.	

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	N
Minimum size:	1
Maximum size:	1
Data domain:	<ul style="list-style-type: none"> 1 Clinician 2 Administrator 3 Teacher/educator 4 Researcher 5 Public health/health promotion 6 Occupational health 7 Environmental health 8 Other (specify) 9 Unknown/inadequately described/not stated

Guide for use:	<p>Code 1: A clinician is a person mainly involved in the area of clinical practice, i.e. diagnosis, care and treatment, including recommended preventative action, to patients or clients. Clinical practice may involve direct client contact or may be practised indirectly through individual case material (as in radiology and laboratory medicine).</p> <p>Code 2: An administrator in a health profession is a person whose main job is in an administrative capacity in the profession, e.g. directors of nursing, medical superintendents, medical advisors in government health authorities, health profession union administrators (e.g. Australian Medical Association, Australian Nurses Federation).</p> <p>Code 3: A teacher/educator in a health profession is a person whose main job is employment by tertiary institutions or health institutions to provide education and training in the profession.</p>
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Code 4: A researcher in a health profession is a person whose main job is to conduct research in the field of the profession, especially in the area of clinical activity. Researchers are employed by tertiary institutions, medical research bodies, health institutions, health authorities, drug companies and other bodies.

Codes 5, 6 and 7: Public health/health promotion, occupational health and environmental health are specialties in medicine, and fields of practice for some other health professions. They are public health rather than clinical practice, and hence are excluded from clinical practice.

Verification rules:

Collection methods: For respondents indicating that their principal professional role is in clinical practice, a more detailed identification of that role is established according to profession-specific categories.

Related metadata:

Administrative Attributes

Source document:

Source organisation: National Health Labour Force Data Working Group

Information model link:

NHIM Labour characteristic

Data Set Specifications:

NMDS - Health labour force

Start date

End date

01/07/1995

Comments:

Procedure

Identifying and Definitional Attributes

Knowledgebase ID: 000137 **Version No:** 5

Metadata type: Data Element

Admin. status: Current
01/07/99

Definition: A clinical intervention that:

- is surgical in nature, and/or
- carries a procedural risk, and/or
- carries an anaesthetic risk, and/or
- requires specialised training, and/or
- requires special facilities or equipment only available in an acute care setting.

Context: This item gives an indication of the extent to which specialised resources, for example, human resources, theatres and equipment are used. It also provides an estimate of the numbers of surgical operations performed and the extent to which particular procedures are used to resolve medical problems. It is used for classification of episodes of acute care for admitted patients into Australian refined diagnosis related groups.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NNNNN-NN

Minimum size: 8

Maximum size: 8

Data domain: ICD-10-AM (3rd edition) procedure codes

Guide for use: Admitted patients:
Record all procedures undertaken during an episode of care in accordance with the ICD-10-AM Australian Coding Standards.
The order of codes should be determined using the following hierarchy:

- procedure performed for treatment of the principal diagnosis
- procedure performed for the treatment of an additional diagnosis
- diagnostic/exploratory procedure related to the principal diagnosis
- diagnostic/exploratory procedure related to an additional diagnosis for the episode of care.

Verification rules: As a minimum requirement procedure codes must be valid codes from ICD-10-AM procedure codes and validated against the nationally agreed age and sex edits. More extensive edit checking of codes may be utilised within individual hospitals and State and Territory information systems.

Collection methods: Record and code all procedures undertaken during the episode of care in accordance with the ICD-10-AM Australian Coding Standards. An unlimited number of diagnosis and procedure codes should be able to be collected in hospital morbidity systems. Where this is not possible, a minimum of 20 codes should be able to be collected. Procedures are derived from and must be substantiated by clinical documentation.

Related metadata:

- is qualified by Additional diagnosis vers 4
- supersedes previous data element Additional procedures – ICD-10-AM code vers 4
- supersedes previous data element Additional procedures – ICD-9-CM code vers 3
- relates to the data element Date of procedure vers 1
- is used in conjunction with Indicator procedure vers 3
- is qualified by Principal diagnosis vers 3
- supersedes previous data element Principal procedure – ICD-10-AM code vers 4
- supersedes previous data element Principal procedure – ICD-9-CM code 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 Centre for Classification in Health
National Health Data Committee

Information model link:

NHIM Service provision event

Data Set Specifications:	Start date	End date
NMDS – Admitted patient care	01/07/1999	

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

Profession labour force status of health professional

Identifying and Definitional Attributes

Knowledgebase ID: 000140 **Version No:** 1

Metadata type: Data Element

Admin. status: Current
01/07/95

Definition: For the national health labour force collections, profession labour force status of a health professional in a particular profession is defined by employment status according to the classification/coding frame below at the time of renewal of registration.

Employment in a particular health profession is defined by practice of that profession or work that is principally concerned with the discipline of the profession (for example, research in the field of the profession, administration of the profession, teaching of the profession or health promotion through public dissemination of the professional knowledge of the profession).

Context: Health labour force:

This data element provides essential data for estimating the size and distribution of the health labour force, monitoring growth, forecasting future supply, and addressing work force planning issues. It was developed by the National Committee for Health and Vital Statistics during the 1980s and endorsed by the Australian Health Ministers' Advisory Council in 1990 as a national minimum data set item for development of the national health labour force collections.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N or N.N

Minimum size: 1

Maximum size: 3

Data domain:

- 1 Employed in the profession: working in/practising the reference profession – in reference State
- 2 Employed in the profession: working in/practising the reference profession – mainly in other State(s) but also in reference State
- 3 Employed in the profession: working in/practising the reference profession – mainly in reference State but also in other State(s)
- 4 Employed in the profession: working in/practising the reference profession – only in State(s) other than reference State
- 5.1 Employed elsewhere, looking for work in the profession: in paid work not in the field of profession but looking for paid work/practice in the profession – seeking either full-time or part-time work
- 5.2 Employed elsewhere, looking for work in the profession: in paid work not in the field of profession but looking for paid work/practice in the profession – seeking full-time work
- 5.3 Employed elsewhere, looking for work in the profession: in paid work not in the field of profession but looking for paid work/practice in the profession – seeking part-time work

- 5.9 Employed elsewhere, looking for work in the profession: in paid work not in the field of profession but looking for paid work/practice in the profession – seeking work (not stated)
- 6.1 Unemployed, looking for work in the profession: not in paid work but looking for work in the field of profession – seeking either full-time or part-time work
- 6.2 Unemployed, looking for work in the profession: not in paid work but looking for work in the field of profession – seeking full-time work
- 6.3 Unemployed, looking for work in the profession: not in paid work but looking for work in the field of profession – seeking part-time work
- 6.9 Unemployed, looking for work in the profession: not in paid work but looking for work in the field of profession – seeking work (not stated)
- 7 Not in the labour force for the profession: not in work/practice in the profession and not looking for work/practice in the profession
- 8 Not in the labour force for the profession: working overseas
- 9 Unknown/not stated

Guide for use:

The term 'employed in the profession' equates to persons who have a job in Australia in the field of the reference profession.

A person who is normally employed in the profession but is on leave at the time of the annual survey is defined as being employed.

A health professional who is not employed but is eligible to work in, and is seeking employment in the profession, is defined as unemployed in the profession.

A health professional looking for work in the profession, and not currently employed in the profession, may be either unemployed or employed in an occupation other than the profession.

A registered health professional who is not employed in the profession, nor is looking for work in the profession, is defined as not in the labour force for the profession.

Registered health professionals not in the labour force for the profession may be either not employed and not looking for work, or employed in another occupation and not looking for work in the profession.

Verification rules:**Collection methods:**

For the national health labour force collection survey questionnaire, this is the key filter question. It excludes from further survey questions at this point:

- persons working overseas although working/practising in the reference profession
- respondents working only in States other than the reference state
- respondents not working in the reference profession and not looking for work in the reference profession

It also directs respondents working in the reference State and other States to respond to subsequent questions only in respect of work in the reference State. These distinctions are necessary in order to eliminate multiple counting for respondents renewing licenses to practise in more than one State.

The definitions of employed and unemployed in this data item differ from Australian Bureau of Statistics (ABS) definitions for these categories defined in LFA2 'Employed persons', LFA8 'Labour force status', LFA9 'Looking for full-time work', LFA10 'Looking for part-time work', LFA12 'Not in the labour force', LFA13 'Status in employment', and LFA14 'Unemployed persons'.

The main differences are:

- The National Health Labour Force Collection includes persons other than clinicians working in the profession as persons employed in the profession. ABS uses the Australian Standard Classification of Occupations where, in general, classes for health occupations do not cover non-clinicians. The main exception to this is nursing where, because of the size of the profession, there are classes for nursing administrators and educators.
- The labour force collection includes health professionals working in the Defence Forces; ABS does not, with the exception of the population census.
- ABS uses a tightly defined reference period for employment and unemployment; the labour force collection reference period is self-defined by the respondent as his/her usual status at the time of completion of the survey questionnaire.
- The labour force collection includes, among persons looking for work in the profession, those persons who are registered health professionals but employed in another occupation and looking for work in the profession; ABS does not.
- The labour force collection includes in the category not in the labour force health professionals registered in Australia but working overseas; such persons are excluded from the scope of ABS censuses and surveys.

Related metadata: relates to the data element concept Health labour force vers 1
relates to the data element concept Occupation vers 1

Administrative Attributes

Source document:

Source organisation: National Health Labour Force Data Working Group

Information model link:

NHIM Labour characteristic

Data Set Specifications:

NMDS - Health labour force

Start date

End date

01/07/1995

Comments:

Proficiency in spoken English

Identifying and Definitional Attributes

Knowledgebase ID: 000643 **Version No:** 1

Metadata type: Data Element

Admin. status: Current
01/07/01

Definition: A person's self-stated proficiency in spoken English.

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

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

0	Not applicable (person under 5 years of age)
1	Very well
2	Well
3	Not well
4	Not at all
5	Not stated/inadequately described

Guide for use: This item is only used in conjunction with 'Main language other than English spoken at home'. The question should only be asked if a YES answer is given to the question 'Do you speak a language other than English at home?'

Code 9 should only be used for past collections where this item was not collected or if the person does not respond to the question. It should not be a response included on the collection form.

Verification rules:

Collection methods:

Suggested question:

How well do you (does the person) speak English?

Very well? ____

Well? ____

Not well? ____

Not at all? ____

Generally this would be a self-reported question, but in some circumstances (particularly where a person does not speak English well) assistance will be required in answering this question. It is important that the person's self-assessed proficiency in spoken English be recorded wherever possible.

This data element does not purport to be a technical assessment of proficiency but is a self-assessment in the four broad categories outlined above.

This data element is not relevant to and should not be collected for persons under the age of 5.

Related metadata: relates to the data element Country of birth vers 3
 relates to the data element Main language other than English spoken at home vers 1

Administrative Attributes

Source document: Standards for Statistics on Cultural and Language Diversity, Australian Bureau of Statistics, Cat. No. 1289.0, 1999

Source organisation: Australian Bureau of Statistics

Information model link:

NHIM Social characteristic

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

Comments: The ABS advises that the most useful information provided by this data element is in the distinction between the two category groups of Very well/Well and Not well/Not at all.

Proteinuria – status

Identifying and Definitional Attributes

Knowledgebase ID:	000673	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/01/03	
Definition:	The presence of excessive protein in the urine of the person.	
Context:	Health care and clinical settings: Proteinuria is one of several indicators for renal disease or of conditions leading to renal disease. Renal disease when detected early is often responsive to intervention.	

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	N(.N)
Minimum size:	1
Maximum size:	3
Data domain:	<ul style="list-style-type: none"> 1 Negative for proteinuria 1.1 Microalbuminuria present 1.2 Microalbuminuria not present 1.3 Microalbuminuria not tested 2 Proteinuria 3 Not tested 9 Not stated/inadequately described

Guide for use:	<p>Dipstick testing can be used to test for protein in a urine specimen. Proteinuria (i.e. excessive protein in the urine) on Dipstick urinalysis is described as one or more pluses of protein and for a 24-hour urine collection where the patient excretes more than 300mg/day of protein.</p> <p>Microalbuminuria can be determined using any one of the following tests: Spot urine, Timed urine (24-hour collection) or Albumin/creatinine ratio. Although the presence of microalbuminuria does not warrant categorisation as proteinuria, it is clinically significant in the diagnosis and treatment of diabetes.</p> <p>Code 1 Negative for proteinuria – less than 1 plus on dipstick-testing or excretion of 300 mg or less of protein from 24-hour urine collection</p> <p>Code 1.1 Microalbuminuria present</p> <p>Code 1.2 Microalbuminuria not present</p> <p>Code 1.3 Microalbuminuria not tested</p> <p>Code 2 Proteinuria – one or more pluses of protein in Dipstick urinalysis or for a 24-hour urine collection, where the patient excretes more than 300 mg/per day of protein.</p>
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Code 3 Not tested – no urinalysis for proteinuria was taken.

Code 9 Not stated/ inadequately described

Verification rules:

Collection methods:

Three test options are available for determining microalbuminuria and consist of spot urine or timed urine (24-hour collection) or Albumin/creatinine ratio. Where laboratory testing is used to determine Proteinuria status the categorisation must be substantiated by clinical documentation such as an official laboratory report.

Related metadata:

relates to the data element Date of diagnosis vers 1

is used in conjunction with Service contact date vers 1

Administrative Attributes

Source document:

Source organisation: CV-Data Working Group

Information model link:

NHIM Assessment event

Data Set Specifications:

DSS – Cardiovascular disease (clinical)

Start date

End date

01/01/2003

Comments:

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

Quality accreditation/certification standard

Identifying and Definitional Attributes

Knowledgebase ID:	000777	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/02	
Definition:	The quality accreditation/certification standard met by the hospital establishment as a whole.	
Context:	Hospitals: Required to identify the quality accreditation/certification standard met by the providers of services.	

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, accredited or certified compliant with the standard</td> </tr> <tr> <td>2</td> <td>No, not accredited or certified compliant with the standard</td> </tr> </table>	1	Yes, accredited or certified compliant with the standard	2	No, not accredited or certified compliant with the standard
1	Yes, accredited or certified compliant with the standard				
2	No, not accredited or certified compliant with the standard				
Guide for use:	<p>Report the status code as at 30 June for each of the following standards (this is a repeating field; one for each of the four accreditation standards listed):</p> <p>1st field: The International Organisation for Standardisation (ISO) 9000 quality family. Examples of the ISO 9000 quality family include: ISO 9001, ISO 9002, ISO 9003, ISO 9004:2000</p> <p>2nd field: Australian Council on Health Care Standards EQuIP</p> <p>3rd field: Quality Improvement Council (QIC)</p> <p>4th field: Australian Quality Council (AQC)</p>				

Verification rules:

Collection methods:

Related metadata:

Administrative Attributes

Source document:

Source organisation: Australian Institute of Health & Welfare

Information model link:

NHIM Organisation characteristic

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

Comments:

Reason for cessation of treatment episode for alcohol and other drugs

Identifying and Definitional Attributes

Knowledgebase ID:	000423	Version No: 2
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/01	
Definition:	The reason for the client ceasing to receive a treatment episode from an alcohol and other drug treatment service.	
Context:	Alcohol and other drug treatment.	

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	NN
Minimum size:	1
Maximum size:	2

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

Guide for use:	Code 1	is to be used when all of the immediate goals of the treatment plan have been fulfilled.
	Code 2	a treatment episode will end if there is a change in the Main treatment type for alcohol and other drugs.
	Code 3	a treatment episode will end if there is a change in the Treatment delivery setting for alcohol and other drugs.
	Code 4	a treatment episode will end if there is a change in the Principal drug of concern.
	Code 5	includes situations where the service provider is no longer the most appropriate and the client is transferred/referred to another service. For example, transfers could occur for clients between non-residential and residential services or between residential services and a hospital.

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

Verification rules:

Collection methods: To be collected on cessation of a treatment episode

Related metadata:

relates to the data element concept Cessation of treatment episode for alcohol and other drugs vers 2

relates to the data element Date of cessation of treatment episode for alcohol and other drugs vers 2

supersedes previous data element Reason for cessation of treatment vers 1

Administrative Attributes**Source document:**

Source organisation: Intergovernmental Committee on Drugs NMDS WG

Information model link:

NHIM Exit/leave from service event

Data Set Specifications:

NMDS - Alcohol and other drug treatment services

Start date

End date

01/07/2001

Comments:

Reason for removal from elective surgery waiting list

Identifying and Definitional Attributes

Knowledgebase ID:	000142	Version No: 4
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/02	
Definition:	The reason why a patient is removed from the waiting list.	

Context:

Elective surgery:

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

Relational and Representational Attributes

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

Data domain:

- | | |
|---|---|
| 1 | Admitted as an elective patient for awaited procedure in this hospital or another hospital |
| 2 | Admitted as an emergency patient for awaited procedure in this hospital or another hospital |
| 3 | Could not be contacted (includes patients who have died while waiting whether or not the cause of death was related to the condition requiring treatment) |
| 4 | Treated elsewhere for awaited procedure, but not as a patient of this hospital's waiting list |
| 5 | Surgery not required or declined |
| 6 | Transferred to another hospital's waiting list |
| 9 | Not known |

Guide for use:

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

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

Codes 3-5 provide an indication of the amount of clerical audit of the waiting lists. Code 4 gives an indication of patients treated other than as a patient of the hospital's waiting list. The awaited procedure may have been performed as an emergency or as an elective procedure.

- Code 6 identifies patients who were transferred from one hospital's elective surgery waiting list to that of another hospital. The waiting time on the waiting lists at the initial hospital and subsequent hospitals should be combined for national reporting.
- Code 9 identifies patients removed from the waiting list for reasons unknown.

Verification rules:**Collection methods:**

Related metadata: supersedes previous data element Reason for removal from elective surgery waiting list vers 3

Administrative Attributes**Source document:**

Hospital Access Program Waiting Lists Working Group

Source organisation:

Waiting Times Working Group

National Health Data Committee

Information model link:

NHIM Exit/leave from service event

Data Set Specifications:

NMDS - Elective surgery waiting times

Start date

End date

01/07/1994

Comments:

Recoveries

Identifying and Definitional Attributes

Knowledgebase ID:	000295	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/89	
Definition:	<p>All revenue received that is in the nature of a recovery of expenditure incurred. This would include:</p> <ul style="list-style-type: none"> - income received from the provision of meals and accommodation to members of staff of the hospital (assuming it is possible to separate this from income from the provision of meals and accommodation to visitors) - income received from the use of hospital facilities by salaried medical officers exercising their rights of private practice and by private practitioners treating private patients in hospital - other recoveries such as those relating to inter-hospital services where the revenue relates to a range of different costs and cannot be clearly offset against any particular cost. <p>Generally, gross revenues should be reported but, where inter-hospital payments for transfers of goods and services are made, offsetting practices are acceptable to avoid double counting. Where a range of inter-hospital transfers of goods and services is involved and it is not possible to allocate the offsetting revenue against particular expenditure categories, then it is acceptable to bring that revenue in through recoveries.</p>	
Context:	<p>Health expenditure:</p> <p>Recoveries represent a significant source of income for many establishments and, as well as assisting in completing the picture in any health financing studies or analysis at the national level, are relevant in relation to the determination of net costs and output costs.</p>	

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Currency
Representational layout:	\$999,999,999
Minimum size:	2
Maximum size:	12
Data domain:	Australian dollars to the nearest whole dollar.
Guide for use:	<p>Record as currency up to hundreds of millions of dollars.</p> <p>This data element relates to all revenue received by establishments except for general revenue payments received from State or Territory governments.</p>
Verification rules:	
Collection methods:	
Related metadata:	relates to the data element Establishment type vers 1

Administrative Attributes

Source document:

Source organisation: National minimum data set working parties

Information model link:

NHIM Financial resource item

Data Set Specifications:

NMDS - Public hospital establishments

Start date

End date

01/07/1989

Comments:

The Resources Working Party had considered splitting recoveries into staff meals and accommodation, and use of hospital facilities (private practice) and other recoveries.

Some States had felt that use of facilities was too sensitive as a separate identifiable item in a national minimum data set. Additionally, it was considered that total recoveries was an adequate category for health financing analysis purposes at the national level.

Referral to further care (psychiatric patients)

Identifying and Definitional Attributes

Knowledgebase ID:	000143	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/89	
Definition:	Referral to further care by health service agencies/facilities.	

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

Relational and Representational Attributes

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

Data domain:	1	Not referred
	2	Private psychiatrist
	3	Other private medical practitioner
	4	Mental health/alcohol and drug inpatient facility
	5	Mental health/alcohol and drug non inpatient facility
	6	Acute hospital
	7	Other

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 Exit/leave from service event

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

Comments:

Referred to ophthalmologist – diabetes mellitus

Identifying and Definitional Attributes

Knowledgebase ID:	000843	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/01/03	
Definition:	Whether the individual was referred to an ophthalmologist within the last 12 months.	
Context:	Public health, health care and clinical settings: Diabetes mellitus specific data element.	

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	N
Minimum size:	1
Maximum size:	1
Data domain:	<p>1 Yes, referred to an ophthalmologist</p> <p>2 No, not referred to an ophthalmologist</p> <p>9 Not stated/inadequately described</p>
Guide for use:	Record whether or not the individual was referred to an ophthalmologist during the last 12 months.
Verification rules:	
Collection methods:	Ask the individual if he/she was referred to an ophthalmologist during the last 12 months. 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 Blindness – diabetes complication vers 1</p> <p>relates to the data element Cataract – history vers 1</p> <p>relates to the data element Ophthalmological assessment – outcome vers 1</p> <p>relates to the data element Ophthalmoscopy – performed vers 1</p> <p>relates to the data element Visual acuity 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**End date**

01/01/2003

Comments:

An ophthalmologist is a physician specialising in diagnosing and prescribing treatment for defects, injuries and diseases of the eye, and who is skilled at delicate eye surgery.

Patients with diabetes have increased risk of developing several eye complications including retinopathy, cataract and glaucoma that may lead to loss of vision.

Regular eye checkup is important for patients suffering from diabetes mellitus. This helps to detect abnormalities early and to avoid or postpone complications.

References:

Diabetes Control and Complications Trial: DCCT New England Journal of Medicine, 329(14), September 30, 1993.

Region code

Identifying and Definitional Attributes

Knowledgebase ID:	000378	Version No: 2
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/97	
Definition:	An identifier for location of health services in a defined geographic or administrative area.	
Context:	All health services.	

Relational and Representational Attributes

Datatype:	Alphanumeric
Representational form:	Code
Representational layout:	AN
Minimum size:	1
Maximum size:	2
Data domain:	Any valid region code created by a jurisdiction.
Guide for use:	Domain values are specified by individual States/Territories. Regions may also be known as Areas or Districts.
Verification rules:	
Collection methods:	
Related metadata:	is a composite part of Establishment identifier vers 4

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:

Removal date

Identifying and Definitional Attributes

Knowledgebase ID:	000798	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/02	
Definition:	Date on which a patient is removed from an elective surgery waiting list.	
Context:	Elective surgery: This data element is necessary for the calculation of the waiting time at removal from an elective surgery waiting list.	

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:	This date is recorded when a patient is removed from an elective surgery waiting list.
Verification rules:	Right justified and zero filled. Removal date >= date of birth Removal date >= listing date for care
Collection methods:	
Related metadata:	is used in the calculation of 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	Exit/leave from service event	
Data Set Specifications:		Start date End date
NMDS - Elective surgery waiting times		01/07/2002
Comments:	Removal date will be the same as admission date for patients in 'reason for removal from elective surgery waiting list' categories 1 and 2.	

Renal disease – end-stage, diabetes complication

Identifying and Definitional Attributes

Knowledgebase ID:	000844	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/01/03	
Definition:	Whether an individual has end-stage renal disease as a complication of diabetes, and has required dialysis or has undergone a kidney transplant.	
Context:	Public health, health care and clinical settings: Diabetes mellitus specific data element.	

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	N
Minimum size:	1
Maximum size:	1
Data domain:	<ul style="list-style-type: none"> 1 End-stage renal disease – developed in the last 12 months 2 End-stage renal disease – developed prior to the last 12 months 3 No end-stage of renal disease 9 Not stated/inadequately described

Guide for use:

Verification rules:

Collection methods: Ask the individual if he/she has required dialysis or has undergone a kidney (renal) transplant (due to diabetic nephropathy). Alternatively obtain the relevant information from appropriate documentation.

Related metadata:

- relates to the data element Blood pressure – diastolic measured vers 1
- relates to the data element Blood pressure – systolic measured vers 1
- relates to the data element Creatinine serum – measured vers 1
- relates to the data element Microalbumin/protein – 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 Physical wellbeing

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

DSS - Diabetes (clinical)

01/01/2003

Comments:

To determine chronic renal impairment: -

Glomerular filtration rate (GFR)

GFR > 90 ml/min normal

GFR > 60-90 ml/min: mild renal impairment

GFR > 30-60 ml/min: moderate renal impairment

GFR 0-30 ml/min: severe renal impairment

For greater than 3 months.

In general, patients with GFR < 30 ml/min/1.73 m² are at high risk of progressive deterioration in renal function and should be referred to a nephrology service for specialist management of renal failure. Patients should be assessed for the complications of chronic renal impairment including anaemia, hyperparathyroidism and be referred for specialist management if required. Patients with rapidly declining renal function or clinical features to suggest that residual renal function may decline rapidly (i.e. hypertensive, proteinuric (>1 g/24 hours), significant co-morbid illness) should be considered for referral to a nephrologist well before function declines to less than 30ml/min. (Draft CARI Guidelines 2002. Australian Kidney Foundation)

Patients in whom the cause of renal impairment is uncertain should be referred to a nephrologist for assessment.

End-stage renal disease is a recognised complication of Type 1 and Type 2 diabetes mellitus. Diabetes is the commonest cause for renal dialysis in Australia.

The term end-stage renal disease has become synonymous with the late stages of chronic renal failure. Diabetic nephropathy may be effectively prevented and treated by controlling glycemia and administering angiotensin-converting enzyme (ACE) inhibitors. J Am Soc Nephrol 2002 Jun; 13(6): 1615-1625].

Renal disease therapy

Identifying and Definitional Attributes

Knowledgebase ID:	000675	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/01/03	
Definition:	The therapy the person is receiving for renal disease.	
Context:	Clinical settings: Its main use is to enable categorisation of management regimes.	

Relational and Representational Attributes

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

Data domain:	1	Drugs for modification of renal disease
	2	Drugs for treatment of complications of renal disease
	3	Peritoneal dialysis
	4	Haemodialysis
	5	Functioning renal transplant

Guide for use:	More than one code can be selected.	
	Code 1	Drugs for modification of renal disease, includes drugs intended to slow progression of renal failure. Examples include antiproteinurics such as angiotensin converting enzyme inhibitors (ACEI), angiotensin II receptor antagonists (ATRA) and immunosuppressants
	Code 2	Drugs for the treatment of the complications of renal disease. Examples include antihypertensive agents and drugs that are intended to correct biochemical imbalances caused by renal disease. (e.g. loop diuretics, ACEI, erythropoietin, calcitriol, etc.).
	Code 3	Peritoneal dialysis, chronic peritoneal dialysis, delivered at home, at a dialysis satellite centre or in hospital.
	Code 4	Haemodialysis, chronic haemodialysis delivered at home, at a dialysis satellite centre or in hospital.
	Code 5	Functioning renal transplant, the presence of a functioning renal transplant.

Verification rules:

Collection methods: To be collected on commencement of treatment and regularly reviewed.

Related metadata: is used in conjunction with Service contact date vers 1

Administrative Attributes

Source document: CARI Guidelines. Australian Kidney Foundation

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:

DSS - Cardiovascular disease (clinical):

Nephrotoxic agents (including radiocontrast) should be avoided where possible. Drugs that impair auto-regulation of glomerular filtration rate (GFR) (NSAIDs, COX-2, ACEI, ATRA) should be used with caution in renal impairment, particularly when patients are acutely unwell for other reasons (sepsis, peri-operative etc.).

Although combination ACEI and diuretic can be a very potent and efficacious means of reducing blood pressure (and thereby slowing progression), either drug should be introduced individually and carefully in a patient with underlying renal impairment. At the very least, diuretic therapy should be held or reduced when commencing an ACEI in a patient with renal impairment. Combination therapy with ACEI, diuretics and NSAIDs or COX-2 may be particularly harmful.

Drugs, which are primarily excreted by the kidney (e.g. metformin, sotalol, cisapride, etc.) need to be used with caution in patients with renal impairment. The calculated GFR needs to be determined and the dose reduced or the drug avoided as appropriate.

Repairs and maintenance

Identifying and Definitional Attributes

Knowledgebase ID:	000242	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/89	
Definition:	The costs incurred in maintaining, repairing, replacing and providing additional equipment, maintaining and renovating building and minor additional works. Expenditure of a capital nature should not be included here. Do not include salaries and wages of repair and maintenance staff. 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 as currency 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 minimum data set working parties	
Information model link:	NHIM Recurrent expenditure	
Data Set Specifications:		
NMDS - Public hospital establishments	Start date	End date
	01/07/1989	

Comments:

Resuscitation of baby

Identifying and Definitional Attributes

Knowledgebase ID:	000145	Version No: 2
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/01	
Definition:	Active measures taken immediately after birth to establish independent respiration and heart beat, or to treat depressed respiratory effort and to correct metabolic disturbances.	
Context:	Perinatal: Required to analyse need for resuscitation after complications of labour and delivery and to evaluate level of services needed for different birth settings.	

Relational and Representational Attributes

Datatype:	Numeric														
Representational form:	Code														
Representational layout:	N														
Minimum size:	1														
Maximum size:	1														
Data domain:	<table> <tr><td>1</td><td>None</td></tr> <tr><td>2</td><td>Suction only</td></tr> <tr><td>3</td><td>Oxygen therapy only</td></tr> <tr><td>4</td><td>Intermittent positive pressure respiration (IPPR) through bag and mask</td></tr> <tr><td>5</td><td>Endotracheal intubation and IPPR</td></tr> <tr><td>6</td><td>External cardiac massage and ventilation</td></tr> <tr><td>9</td><td>Not stated</td></tr> </table>	1	None	2	Suction only	3	Oxygen therapy only	4	Intermittent positive pressure respiration (IPPR) through bag and mask	5	Endotracheal intubation and IPPR	6	External cardiac massage and ventilation	9	Not stated
1	None														
2	Suction only														
3	Oxygen therapy only														
4	Intermittent positive pressure respiration (IPPR) through bag and mask														
5	Endotracheal intubation and IPPR														
6	External cardiac massage and ventilation														
9	Not stated														

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

Verification rules:

Collection methods:

Related metadata:

- is used in conjunction with Apgar score vers 1
- is used in conjunction with Apgar score at 5 minutes vers 1
- supersedes previous data element Resuscitation of baby vers 1
- is used in conjunction with Status of the baby vers 1

Administrative Attributes

Source document:

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Birth event

Data Set Specifications:

Start date

End date

Comments: