Data Elements
N – O

Name

Identifying and Definitional Attributes

Knowledgebase ID: ***000835*** ***Version No: 1***

Metadata type: Data Element Concept

Admin. status: Current

01/01/03

Definition: A person's full identifying name within any social context in which a person may be identified as an individual.

Context:

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 Family name vers 1

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

relates to the data element Name context flag vers 1

relates to the data element Name suffix vers 1

relates to the data element Name title vers 1

relates to the data element Name type vers 1

Administrative Attributes

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

Source organisation: Standards Australia

Information model link:

NHIM Person characteristic

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

Comments:

Name context flag

Identifying and Definitional Attributes

Knowledgebase ID: ***000785*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: An indicator of specific conditions that should be applied to a particular person's name.

Context:

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 0

Maximum size: 1

Data domain:

1 Unreliable information

2 Name not for continued use

3 Special privacy/security requirement

Guide for use: Field value definitions are:

1 Unreliable information: should be used where it is known that the name recorded is a fictitious or partial name. These names should not be used for matching client data.

2 Name not for continued use: certain tribal names may become 'not for continued use'.

3 Special privacy/security requirement: may apply to names for which episodes are attached that should only be accessible to specified authorised persons. There must be a specific need to implement this additional security level. Local policy should provide guidance to the use of this code.

Verification rules: Valid codes or blank.

Collection methods:

Related metadata:

relates to the data element Family name vers 1

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

relates to the data element concept Name vers 1

relates to the data element Name suffix vers 1

relates to the data element Name title vers 1

relates to the data element Name type vers 1

Administrative Attributes

Source document: AS5017 Health care client identification

Source organisation: Standards Australia

Information model link:

NHIM Person characteristic

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

Comments:

Name suffix

Identifying and Definitional Attributes

Knowledgebase ID:	***000783***	***Version No: 1***
Metadata type:	Data Element	
Admin. status:	Current 01/01/03	
Definition:	Additional term following a person's name used to identify a person when addressing them by name, whether by mail, by phone or in person.	
Context:		

Relational and Representational Attributes

Datatype: Alphabetic

Representational form: Text

Representational layout: A(12)

Minimum size: 0

Maximum size: 12

Data domain: Name suffix should be abbreviated in accordance with Australian Standard AS4590-1999 Interchange of client information. For example:

Jr	Junior
MP	Member of Parliament
QC	Queens Council
Sr	Senior
I	First
II	Second
III	Third
IV	Fourth
V	Fifth
VI	Sixth
VII	Seventh
VIII	Eighth
IX	Ninth
X	Tenth

Guide for use: Mixed case should be used (rather than upper case only).

More than one Name suffix may be collected.

Use a single space between each suffix.

Verification rules:

Collection methods:

Related metadata: relates to the data element Family name vers 1

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

relates to the data element concept Name vers 1

relates to the data element Name context flag vers 1

relates to the data element Name title vers 1

relates to the data element Name type vers 1

Administrative Attributes

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

Source organisation: Standards Australia

Information model link:

NHIM Person characteristic

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

Comments:

Name title

Identifying and Definitional Attributes

Knowledgebase ID: ***000780*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: An honorific form of address, commencing a name, used when addressing a person by name, whether by mail, by phone or in person.

Context:

Relational and Representational Attributes

Datatype: Alphabetic

Representational form: Text

Representational layout: A(12)

Minimum size: 0

Maximum size: 12

Data domain: Name title should be abbreviated in accordance with Australian Standard AS4590-1999 Interchange of client information. For example:

Br Brother

Dame Dame

Dr Doctor

Mstr Master

Miss Miss

Mr Mister

Mrs Mrs

Ms Ms

Prof Professor

Rev Reverend

Sir Sir

Sr Sister

Guide for use: Name title should not be confused with job title.

Mixed case should be used (rather than upper case only).

Verification rules: Title of Master should only be used for persons less than 15 years of age.

Titles of Doctor and Professor should only be applicable to persons of greater than 20 years of age

Collection methods:

Related metadata: relates to the data element Family name vers 1

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

relates to the data element concept Name vers 1

relates to the data element Name context flag vers 1

relates to the data element Name suffix vers 1

relates to the data element Name type vers 1

Administrative Attributes

Source document: AS 5017 Health care client identification

Source organisation: Standards Australia

Information model link:

NHIM Social characteristic

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

Comments:

Name type

Identifying and Definitional Attributes

Knowledgebase ID: ***000784*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: A classification that enables differentiation between recorded names for a person.

Context:

Relational and Representational Attributes

Datatype: Alphabetic

Representational form: Code

Representational layout: A

Minimum size: 1

Maximum size: 1

Data domain:

A Alias name

M Medicare card name

N Newborn name

P Preferred name

Guide for use: More than one name can be recorded for a person who is a health care client. That is, this field is a multiple occurring field. At least one name must be recorded for each person and each name must have an appropriate Name type.

One name is sufficient, however, where the person offers more than one name, clarification should be obtained from the person to ensure accurate identification of the person and recording of the various names. Both currently used names, as well as names by which the person has previously been known, should be recorded if these are known.

Field value definitions for Name type codes are:

Preferred name (P): is the name by which the person chooses to be identified.

There should only be one preferred name recorded for a person. Where the person changes their preferred name, record the previously recorded preferred name as an Alias name. Preferred name is the default name type (i.e. if only one name is recorded it should be the person's Preferred name). There must be a Preferred name recorded except for unnamed newborns where the Newborn name is the only name recorded.

Also, if the person is a health care client, record his/her Medicare card name if different to the Preferred name, and any known Alias names.

Medicare card name (M): is the person's name as it appears on their Medicare card. The name stated on the Medicare card is required for all electronic Medicare claim lodgement. If the Preferred name of the person is different to the name on the Medicare card, the Medicare card name should also be recorded.

Newborn name (N): type is reserved for the identification of unnamed newborn babies.

Alias name (A): is any other name that a person is also known by, or has been known by in the past; that is, all alias names. This includes misspelt names or name variations that are to be retained as they have been used to identify this person. More than one alias name may be recorded for a person.

Where a person provides a name that can be in more than one Name type category, the Name type with the highest order of precedence should be used. Multiple versions of the same name can however be recorded.

Verification rules:

Collection methods:

Related metadata: relates to the data element Family name vers 1

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

relates to the data element concept Name vers 1

relates to the data element Name context flag vers 1

relates to the data element Name suffix vers 1

relates to the data element Name title vers 1

Administrative Attributes

Source document: AS5017 Health care client identification

Source organisation: Standards Australia

Information model link:

NHIM Social characteristic

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

Comments:

Narrative description of injury event

Identifying and Definitional Attributes

Knowledgebase ID: ***000099*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current
01/07/96

Definition: A text description of the injury event.

Context: Injury surveillance:

The narrative of the injury event is very important to injury control workers as it identifies features of the event not revealed by coded data.

Relational and Representational Attributes

Datatype: Alphanumeric

Representational form: Text

Representational layout: A(100)

Minimum size: 0

Maximum size: 100

Data domain: Text up to 100 characters in length

Guide for use: Write a brief description of how the injury occurred. It should indicate what went wrong (the breakdown event), the mechanism by which this event led to injury and the object(s) or substance(s) most important in the event. The type of place at which the event occurred, and the activity of the person who was injured should also be indicated.

Verification rules:

Collection methods:

Related metadata: is qualified by Activity when injured vers 2

is qualified by External cause – human intent vers 4

Administrative Attributes

Source document:

Source organisation: National Injury Surveillance Unit

Information model link:

NHIM Injury event

Data Set Specifications:	*Start date*	*End date*
NMDS – Injury surveillance	01/07/1996	

Comments: This is a basic item for injury surveillance. The text description of the injury event is structured to indicate context, place, what went wrong and how the event resulted in injury. Further information on the national injury surveillance program can be obtained from the National Injury Surveillance Unit, Flinders University, Adelaide.

Nature of main injury – non-admitted patient

Identifying and Definitional Attributes

Knowledgebase ID: ***000087*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/96

Definition: The nature of the injury chiefly responsible for the attendance of the person at the health care facility.

Context: Injury surveillance:

Injury diagnosis is necessary for purposes including epidemiological research, casemix studies and planning. This item, together with data element Bodily location of main injury, indicates the diagnosis.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NN or NN.N

Minimum size: 2

Maximum size: 4

Data domain:

01 Superficial (excludes eye [13])
02 Open wound (excludes eye [13])
03 Fracture (excludes tooth [21])
04 Dislocation (includes ruptured disc, cartilage, ligament)
05 Sprain or strain
06 Injury to nerve (includes spinal cord; excludes intracranial injury [20])
07 Injury to blood vessel
08 Injury to muscle or tendon
09 Crushing injury
10 Traumatic amputation (includes partial amputation)
11 Injury to internal organ
12 Burn or corrosion (excludes eye [13])
13 Eye injury (excludes foreign body in external eye [14.1], includes burns)
14.1 Foreign body in external eye
14.2 Foreign body in ear canal
14.3 Foreign body in nose
14.4 Foreign body in respiratory tract (excludes foreign body in nose [14.3])
14.5 Foreign body in alimentary tract
14.6 Foreign body in genitourinary tract
14.7 Foreign body in soft tissue
14.9 Foreign body, other/unspecified
20 Intracranial injury (includes concussion)
21 Dental injury (includes fractured tooth)
22 Drowning, immersion

23 Asphyxia or other threat to breathing (excludes drowning [22])
24 Electrical injury
25 Poisoning, toxic effect (excludes venomous bite [26])
26 Effect of venom, or any insect bite
27 Other specified nature of injury
28 Injury of unspecified nature
29 Multiple injuries of more than one 'nature'
30 No injury detected

Guide for use: If the full ICD-10-AM code is used to code the injury, this item is not required (see data elements Principal diagnosis and Additional diagnosis). When coding to the full ICD-10-AM code is not possible, use this item with the data elements External cause of injury – non admitted patient, External cause of injury – human intent and Bodily location of main injury.

Select the item which best characterises the nature of the injury chiefly responsible for the attendance, 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. A major injury, if present, should always be coded rather than a minor injury. If a major injury has been sustained (e.g. a fractured femur), along with one or more minor injuries (e.g. some small abrasions), the major injury should be coded in preference to coding 'multiple injuries'. As a general guide, an injury which, on its own, would be unlikely to have led to the attendance may be regarded as 'minor'.

If the nature of the injury code is 01 to 12 or 26 to 29 then data element Bodily location of main injury should be used to record the bodily location of the injury. If another code is used, bodily location is implicit or meaningless. Data element Bodily location of main injury, category 22 may be used as a filler to indicate that specific body region is not required.

Verification rules: Left justified, zero filled.

Collection method

Related metadata: is used in conjunction with Bodily location of main injury vers 1

is used in conjunction with External cause – human intent vers 4

is used in conjunction with External cause – non-admitted patient vers 4

Administrative Attributes

Source document:

Source organisation: AIHW National Injury Surveillance Unit and National Data Standards for Injury Surveillance Advisory Group

Information model link:

NHIM Physical wellbeing

Data Set Specifications:	***Start date***	***End date***
NMDS – Injury surveillance	01/07/1996	

Comments: This item is related to the ICD-10-AM injury and poisoning classification. However, coding to the full ICD-10-AM injury and poisoning classification (see data element Principal diagnosis) is not available in most settings where basic injury surveillance is undertaken. This item, in combination with the data element Bodily location of main injury, is a practicable alternative. Data coded to the full ICD-10-AM codes can be aggregated to match this item, facilitating data comparison. Further information on the national injury surveillance program can be obtained from the National Injury Surveillance Unit, Flinders University, Adelaide.

Need for interpreter service

Identifying and Definitional Attributes

Knowledgebase ID: ***000100*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current
01/07/89

Definition: Need for interpreter services (yes/no) as perceived by the person.

Context: To assist in planning for provision of interpreter services.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:
0 Interpreter not needed
1 Interpreter needed

Guide for use:

Verification rules:

Collection methods:

Related metadata: is used in conjunction with Preferred language vers 2

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Social characteristic

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

Comments: This data element has not been included in the NMDS – Admitted patient care because of reservations about its utility in assessing demand for interpreter services and concerns that a question of this nature might raise expectations of service provision which could not always be fulfilled.

Neonatal death

Identifying and Definitional Attributes

Knowledgebase ID: ***000101*** ***Version No: 1***

Metadata type: Data Element Concept

Admin. status: Current

01/07/96

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

Context: Perinatal.

Relational and Representational Attributes

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 Status of the baby vers 1

Administrative Attributes

Source document: International Classification of Diseases, Tenth Revision – WHO, 1992

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Death event

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

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

Neonatal morbidity

Identifying and Definitional Attributes

Knowledgebase ID: ***000102*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/98

Definition: Conditions or diseases of the baby.

Context: Perinatal statistics:

Morbidity of a baby is an important determinant of outcome and duration of hospital stay.

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: Conditions should be coded within chapter of Volume 1, ICD-10-AM

Collection methods:

Related metadata: is used in conjunction with Congenital malformations vers 2

is used in conjunction with Congenital malformations – BPA code vers 1

supersedes previous data element Neonatal morbidity – ICD-9-CM code vers 1

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:

Neonate

Identifying and Definitional Attributes

Knowledgebase ID: ***000103*** ***Version No: 1***

Metadata type: Data Element Concept

Admin. status: Current

01/07/95

Definition: A live birth who is less than 28 days old.

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: International Classification of Diseases and Related Health Problems, Tenth Revision – WHO, 1992

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

Information model link:

NHIM Person characteristic

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

Comments: The neonatal period is exactly four weeks or 28 completed days, commencing on the date of birth (day 0) and ending on the completion of day 27. For example, a baby born on 1 October remains a neonate until completion of the four weeks on 28 October and is no longer a neonate on 29 October.

New/repeat status

Identifying and Definitional Attributes

Knowledgebase ID: ***000435*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/00

Definition: A new non-admitted patient service event is one for a problem not previously addressed at the same clinical service.

All other non-admitted patient service events are repeat service events.

Context: Hospital non-admitted patient care.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1 New non-admitted patient service event

2 Repeat non-admitted patient service event

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

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

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

Verification rules:

Collection methods:

Related metadata: is used in conjunction with Individual/group session vers 1

is used in conjunction with Multi-disciplinary team status vers 1

is used in conjunction with Non-admitted patient service event vers 1

is used in conjunction with Non-admitted patient service event – patient present status vers 1

is used in conjunction with Non-admitted patient service mode vers 1

is used in conjunction with Non-admitted patient service type vers 1

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Assessment event

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

Comments:

Newborn qualification status

Identifying and Definitional Attributes

Knowledgebase ID: ***000343*** ***Version No: 2***

Metadata type: Data Element Concept

Admin. status: Current

01/07/00

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

Context: Admitted patient care:

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

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use: A newborn qualification status is assigned to each patient day within a newborn episode of care.

A newborn patient day is qualified if the infant meets at least one of the following criteria:

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

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

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

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

Verification rules:

Collection methods:

Related metadata: is used in conjunction with Admitted patient vers 3

is used in conjunction with Care type vers 4

is used in the calculation of Date of change to qualification status vers 1

is used in the calculation of Number of qualified days for newborns vers 2

supersedes previous data element Qualification status vers 1

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Service provision event

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

Comments:

All babies born in hospital are admitted patients.

The newborn baby's qualified days are eligible for health insurance benefits purposes and the patient day count under the Australian Health Care Agreements. In this context, newborn qualified days are equivalent to acute days and may be denoted as such.

The days when a newborn baby does not meet these criteria are classified as unqualified (if they are nine days old or less) and should not be counted as patient days under the Australian Health Care Agreements and are not eligible for health insurance benefit purposes.

Non-admitted patient

Identifying and Definitional Attributes

Knowledgebase ID: ***000104*** ***Version No: 1***

Metadata type: Data Element Concept

Admin. status: Current

01/07/94

Definition: A patient who does not undergo a hospital's formal admission process.

There are three categories of non-admitted patient:

- emergency department patient
- outpatient
- other non-admitted patient (treated by hospital employees off the hospital site – includes community/outreach services)

Context: Non-admitted patient care.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related metadata: relates to the data element concept Patient vers 1

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Recipient role

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

Comments:

Non-admitted patient Emergency department service episode

Identifying and Definitional Attributes

Knowledgebase ID: ***000836*** ***Version No: 1***

Metadata type: Data Element Concept

Admin. status: Current

01/07/03

Definition: The treatment or care between when a patient presents at an Emergency department and when the non-admitted patient Emergency department treatment or care ends.

Context: Emergency department care.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use: Includes patients who do not wait for treatment once registered or triaged, and those who are dead on arrival at the Emergency department.

Both a non-admitted patient Emergency department service episode and an admitted patient episode of care should be recorded for patients who subsequently undergo a formal admission. The end of the non-admitted patient Emergency department service episode should indicate the commencement of the admitted episode of care, if applicable.

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

Verification rules:

Collection methods:

Related metadata: relates to the data element Date patient presents vers 2

relates to the data element concept Emergency department – public hospital vers 1

relates to the data element Length of non-admitted patient Emergency department service episode vers 1

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

relates to the data element Time patient presents vers 2

Administrative Attributes

Source document:

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

Information model link:

NHIM Service provision event

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

Comments: This data element concept has been defined to support the National Minimum Data Set for Non-admitted patient Emergency department care.

Non-admitted patient service event

Identifying and Definitional Attributes

Knowledgebase ID: ***000438*** ***Version No: 1***

Metadata type: Data Element Concept

Admin. status: Current

01/07/00

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

Context: Hospital non-admitted patient care:

This definition applies to non-admitted hospital patients and is not intended to apply to Community-based services.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

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

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

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

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

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

Service events delivered via a telephone call are included if

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

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

If a carer/relative accompanies a patient during a service event, this is not considered to be a service event for the carer/relative, provided that the carer/relative is not a patient in their own right for the service contact.

Where both are patients, it is considered that service events have been provided for the person(s) in whose medical record the service event is noted.

A service event is regarded as having occurred when a consultation occurs between their carer/relative and a service provider at an appointment when the patient is not present, provided that the carer/relative is not a patient in their own right for the service contact. Where both are patients, it is considered that service events have been provided for the person(s) in whose medical record the service event is noted.

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

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

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

Definitions:

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

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

Verification rules:

Collection methods:

Related metadata:

is used in conjunction with Individual/group session vers 1

is used in conjunction with Multi-disciplinary team status vers 1

is used in conjunction with Non-admitted patient service event – patient present status vers 1

is used in conjunction with Non-admitted patient service event count vers 1

is used in conjunction with Non-admitted patient service mode vers 1

is used in conjunction with Non-admitted patient service type vers 1

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Service provision event

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

Comments:

Non-admitted patient service event – patient present status

Identifying and Definitional Attributes

Knowledgebase ID: ***000436*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/00

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

Context: Hospital non-admitted patient care.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1 Patient present with or without carer(s)/relative(s)

2 Carer(s)/relative(s) of the patient only

Guide for use: A service event is regarded as having occurred when a consultation occurs between their carer/relative and a service provider at an appointment when the patient is not present, provided that the carer/relative is not a patient in their own right for the service contact. Where both are patients, it is considered that service events have been provided for the person(s) in whose medical record the service event is noted.

Verification rules:

Collection methods:

Related metadata:

is used in conjunction with Individual/group session vers 1

is used in conjunction with Multi-disciplinary team status vers 1

is used in conjunction with Non-admitted patient service event vers 1

is used in conjunction with Non-admitted patient service event count vers 1

is used in conjunction with Non-admitted patient service mode vers 1

is used in conjunction with Non-admitted patient service type vers 1

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Assessment event

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

Comments:

Non-admitted patient service event count

Identifying and Definitional Attributes

Knowledgebase ID: ***000437*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/00

Definition: The number of service events provided to non-admitted patients in the reference period, for each of the clinical service types in the hospital.

Context: Hospital non-admitted patient care – public patients only.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NNNNNNN

Minimum size: 1

Maximum size: 7

Data domain: Count of non-admitted patient service events for each of the clinical service types listed in the data domain of the data element Non-admitted patient service type.

Guide for use: For each non-admitted patient service event count, specify the

- Service type
- Multi-disciplinary team status
- Individual/group session status
- Patient present status
- Service mode

Verification rules:

Collection methods:

Related metadata:

is used in conjunction with Individual/group session vers 1

is used in conjunction with Multi-disciplinary team status vers 1

is used in conjunction with Non-admitted patient service event vers 1

is used in conjunction with Non-admitted patient service event – patient present status vers 1

is used in conjunction with Non-admitted patient service mode vers 1

is used in conjunction with Non-admitted patient service type vers 1

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Performance indicator

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

Comments: Public patients are defined in accordance with the 1998-2003 Australian Health Care Agreements.

Non-admitted patient service mode

Identifying and Definitional Attributes

Knowledgebase ID: ***000439*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current
01/07/00

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

Context: Hospital non-admitted patient care.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N or N.N

Minimum size: 1

Maximum size: 3

Data domain:

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

Guide for use: Patient and provider in the same physical location refers to face-to-face contacts. If this occurs at the hospital campus of the provider, use code 1.1. If the service event does not occur on the hospital campus of the provider (hospital-based outreach services), use code 1.2.

Hospital-based outreach service events occur when the patient is treated by hospital staff in a location that is not part of the hospital campus (such as in the patient's home or place of work).

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

A service event delivered via a telephone call is included if

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

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

Verification rules:

Collection methods:

Related metadata: is used in conjunction with Individual/group session vers 1
is used in conjunction with Multi-disciplinary team status vers 1
is used in conjunction with Non-admitted patient service event vers 1
is used in conjunction with Non-admitted patient service event count vers 1
is used in conjunction with Non-admitted patient service type vers 1

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Service provision event

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

Comments:

Non-admitted patient service type

Identifying and Definitional Attributes

Knowledgebase ID: ***000440*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/00

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

Context: Hospital non-admitted patient care:

This definition applies to non-admitted hospital patients and is not intended to apply to Community-based services.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N or NN

Minimum size: 1

Maximum size: 2

Data domain:

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

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

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

Examples of clinical service types follow:

Clinical service type	Clinical service examples
Allied health and/or clinical nurse specialist	Audiology
	Clinical pharmacy
	Diabetes education
	Neuropsychology
	Nutrition/dietetics
	Occupational therapy
	Optometry
	Orthoptics
	Orthotics
	Physiotherapy
	Podiatry
	Prosthetics
	Psychology
	Social work
	Speech pathology
	Stomal therapy
	Wound management
Dental	Dental
Imaging	Medical imaging
Medical	Aged care
	Alcohol and other drug
	Allergy
	Anti-coagulant
	Asthma
	Cardiology
	Clinical measurement
	Dermatology
	Dementia
	Developmental disabilities
	Diabetes
	Endocrine
	Epilepsy
	Falls
	Gastroenterology
	General internal medicine
	Genetic
	Haematology
	Hepatobiliary
	Hypertension
	Hyperbaric medicine
	Immunology
	Infectious diseases
	Medical oncology
	Metabolic bone

Clinical service type	Clinical service examples
Medical (continued)………………………..	Nephrology
	Neurology
	Occupational medicine
	Pain management
	Palliative care
	Pulmonary
	Radiation oncology
	Rehabilitation
	Respiratory
	Rheumatology
	Spinal
	Transplants
Obstetrics and gynaecology ……………..	Family planning
	Gynaecology
	Gynaecology oncology
	Obstetrics
	Assisted reproductive technology
Pathology ………………………………..	Pathology
Paediatrics ……………………………….	Adolescent health
	Neonatal
	Paediatric medicine
	Paediatric surgery
Pharmacy ………………………………..	Dispensing pharmacy
Psychiatric ……………………………….	Psychiatry
Surgical …………………………………..	Breast
	Burns
	Cardiac surgery
	Colorectal
	Craniofacial
	Ear, nose and throat
	Fracture
	General surgery
	Neurosurgery
	Ophthalmology
	Orthopaedics
	Plastic surgery
	Pre-admission
	Pre-anaesthesia
	Thoracic surgery
	Urology
	Vascular surgery
Emergency department …………………	Emergency department

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

Verification rules:

Collection methods:

Related metadata:

is used in conjunction with Individual/group session vers 1
is used in conjunction with Multi-disciplinary team status vers 1
is used in conjunction with New/repeat status vers 1
is used in conjunction with Non-admitted patient service event vers 1
is used in conjunction with Non-admitted patient service event count vers 1

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Service provision event

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

Comments:

Non-elective care

Identifying and Definitional Attributes

Knowledgebase ID: ***000105*** ***Version No: 1***

Metadata type: Data Element Concept

Admin. status: Current

01/07/96

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

Context: Institutional health care.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related metadata:

Administrative Attributes

Source document:

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

Information model link:

NHIM Service provision event

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

Comments:

Non-salary operating costs

Identifying and Definitional Attributes

Knowledgebase ID: ***000360*** ***Version No: 1***

Metadata type: Derived Data Element

Admin. status: Current

01/07/98

Definition: Total expenditure relating to non-salary operating items.

Context: Health care:

This data element is required to monitor trends of expenditure in the sector.

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: Record values up to hundreds of millions of dollars.

Total is calculated from expenditure including:

- Payments to visiting medical officers
- Superannuation employer contributions (including funding basis)
- Drug supplies
- Medical and surgical supplies
- Food supplies
- Domestic services
- Repairs and maintenance
- Patient transport
- Administrative expenses
- Interest payments
- Depreciation
- Other recurrent expenditure.

Expenditure should include both the specific costs directly associated with the service and indirect costs for example personnel services.

Research and academic units that function as an integral part of ambulatory care should be reported against the appropriate service.

Validation rule:

Collection methods:

Related metadata:

is calculated using Administrative expenses vers 1

is calculated using Depreciation vers 1

is calculated using Domestic services vers 1

is calculated using Drug supplies vers 1

is calculated using Food supplies vers 1

is calculated using Interest payments vers 1

is calculated using Medical and surgical supplies vers 1

is calculated using Other recurrent expenditure vers 1

is calculated using Patient transport vers 1

is calculated using Payments to visiting medical officers vers 1

is calculated using Repairs and maintenance vers 1

is calculated using Superannuation employer contributions (including funding basis) vers 1

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Recurrent expenditure

Data Set Specifications:	***Start date***	***End date***
NMDS - Community mental health establishments	01/07/1998	

Comments:

Number of available beds for admitted patients

Identifying and Definitional Attributes

Knowledgebase ID: ***000255*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/97

Definition: An available bed is a bed which is immediately available to be used by an admitted patient or resident if required. A bed is immediately available for use if it is located in a suitable place for care with nursing and auxiliary staff available within a reasonable period.

Inclusions: both occupied and unoccupied beds are included. For residential aged care services, the number of approved beds includes beds approved for respite care.

Exclusions: surgical tables, recovery trolleys, delivery beds, cots for normal neonates, emergency stretchers/beds not normally authorised or funded and beds designated for same-day non-admitted patient care are excluded. Beds in wards which were closed for any reason (except weekend closures for beds/wards staffed and available on weekdays only) are also excluded.

Context: Necessary to provide an indicator of the availability and type of service for an establishment.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNNN

Minimum size: 1

Maximum size: 4

Data domain: Average available beds, rounded to the nearest whole number

Guide for use: The average bed is to be calculated from monthly figures.

Verification rules:

Collection methods:

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

supersedes previous data element Number of available beds for admitted patients vers 1

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Aggregate resource

Data Set Specifications:	***Start date***	***End date***
NMDS – Public hospital establishments	01/07/1997	
NMDS – Community mental health establishments	01/07/1998	

Comments: This National Health Data Dictionary entry was amended during 1996–97. Until then, both average and end-of-year counts of available beds were included, and the end-of-year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate characterisation of establishments and comparisons.

Number of contacts (psychiatric outpatient clinic/day program)

Identifying and Definitional Attributes

Knowledgebase ID: ***000141*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/89

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

Context: Mental health statistics:

This data element gives a measure of the level of service provided.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNN

Minimum size: 1

Maximum size: 3

Data domain: Count in number of days

Guide for use:

Verification rules:

Collection methods: All States and Territories where there are public psychiatric hospitals also collect date of contact, and number of contacts during the financial year can be derived from this. (Collection status for New South Wales is unknown at time of writing.)

Related metadata: is an alternative to Number of service contact dates vers 2

Administrative Attributes

Source document:

Source organisation: National minimum data set working parties

Information model link:

NHIM Service provision event

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

Comments: In December 1998, the National Health Information Management Group decided that the new version of this data element (named Number of service contact dates) would be implemented from 1 July 2000 in the NMDS – Community mental health. Until then agencies involved in the NMDS – Community mental health may report either Number of contacts (psychiatric outpatient clinic/day program) or Number of service contact dates with the expectation that agencies will make their best efforts to report against the new version of this data element (Number of service contact dates) from 1 July 1999.

Number of days in special/neonatal intensive care

Identifying and Definitional Attributes

Knowledgebase ID: ***000009*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/97

Definition: Number of days spent by a neonate in a special care or neonatal intensive care nursery (in the hospital of birth).

Context: Admitted patient care and perinatal statistics:
An indicator of the requirements for hospital care of high-risk babies in specialised nurseries that add to costs because of extra staffing and facilities.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNN

Minimum size: 1

Maximum size: 3

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

Guide for use: The number of days is calculated from the date the baby left the special/neonatal intensive care unit minus the date the baby was admitted to the special/neonatal intensive care unit.

Verification rules:

Collection methods: This item is to be completed if baby has been treated in an intensive care unit or a special care nursery (SCN).

SCN are staffed and equipped to provide a full range of neonatal services for the majority of complicated neonatal problems, including short-term assisted ventilation and intravenous therapy.

Neonatal intensive care nurseries (NICN) are staffed and equipped to treat critically ill newborn babies including those requiring prolonged assisted respiratory support, intravenous therapy, and alimentation and treatment of serious infections. Full supportive services are readily available throughout the hospital. These NICN also provide consultative services to other hospitals.

Related metadata: supersedes previous data element Admission to special/neonatal intensive care vers 1

Administrative Attributes

Source document:

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Service provision event

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

Comments:

Number of days of hospital-in-the-home care

Identifying and Definitional Attributes

Knowledgebase ID: ***000640*** ***Version No: 1***

Metadata type: Derived Data Element

Admin. status: Current

01/07/01

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

Context: Admitted patient care.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNN

Minimum size: 0

Maximum size: 3

Data domain: Count of patient days.

Guide for use: The rules for calculating the number of hospital in the home days are outlined below:

- The number of hospital in the home days is calculated with reference to the date of admission, date of separation, leave days and any date(s) of change between hospital and home accommodation.
- The date of admission is counted if the patient was at home at the end of the day.
- The date of change between hospital and home accommodation is counted if the patient was at home at the end of the day.
- The date of separation is not counted, even if the patient was at home at the end of the day.
- The normal rules for calculation of patient days apply, for example in relation to leave and same day patients.

Collection methods:

Related metadata: relates to the data element Admission date vers 4

relates to the data element concept Admitted patient vers 3

relates to the data element concept Episode of care vers 1

relates to the data element concept Hospital-in-the-home care vers 1

relates to the data element Separation date vers 5

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 - Admitted patient care	01/07/2001	

Comments: Number of days of hospital-in-the-home care data will be collected from all States and Territories except Western Australia from 1 July 2001. Western Australia will begin to collect data from a later date.

Number of leave periods

Identifying and Definitional Attributes

Knowledgebase ID: ***000107*** ***Version No: 3***

Metadata type: Data Element

Admin. status: Current

01/07/96

Definition: Number of leave periods in a hospital stay (excluding one-day leave periods for admitted patients).

Leave period is a temporary absence from hospital, with medical approval for a period no greater than seven consecutive days.

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

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NN

Minimum size: 1

Maximum size: 2

Data domain: Count of leave periods.

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

Verification rules:

Collection methods:

Related metadata: is used in the derivation of Length of stay vers 3

supersedes previous data element Number of leave periods vers 2

supersedes previous derived data element Number of leave periods exceeding ten days 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 – Admitted patient care	01/07/1996	

Comments: This data element was modified in July 1996 to exclude the previous differentiation between the psychiatric and other patients at the instigation of the National Mental Health Strategy Committee.

Number of qualified days for newborns

Identifying and Definitional Attributes

Knowledgebase ID: ***000346*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/00

Definition: The number of qualified newborn days occurring within a newborn episode of care.

Context: Admitted patient care – newborn episodes of care only.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNNNN

Minimum size: 1

Maximum size: 5

Data domain: Count of the number of days.

Guide for use: The rules for calculating the number of qualified newborn days are outlined below. The number of qualified days is calculated with reference to the date of admission, date of separation and any date(s) of change to qualification status:

- the date of admission is counted if the patient was qualified at the end of the day
- the date of change to qualification status is counted if the patient was qualified at the end of the day
- the date of separation is not counted, even if the patient was qualified on that day
- the normal rules for calculation of patient days apply, for example in relation to leave and same day patients

The length of stay for a newborn episode of care is equal to the sum of the qualified and unqualified days.

Verification rules:

Collection methods:

Related metadata: is used in conjunction with Date of change to qualification status vers 1

is used in conjunction with Newborn qualification status vers 2

supersedes previous data element Number of acute (qualified)/unqualified days for newborns vers 1

is used in the calculation of Patient days vers 3

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Performance indicator

Data Set Specifications:	***Start date***	***End date***
NMDS – Admitted patient care	01/07/2000	

Comments:

Number of service contact dates

Identifying and Definitional Attributes

Knowledgebase ID: ***000141*** ***Version No: 2***

Metadata type: Derived Data Element

Admin. status: Current

01/07/99

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

Context: Community-based mental health care:

This data element gives a measure of the level of service provided to a patient/client.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNN

Minimum size: 1

Maximum size: 3

Data domain: Count of dates of contact

Guide for use: This data element is a count of service contact dates recorded on a patient or client record. Where multiple service contacts occur on the same date, the date is counted only once.

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

Verification rules:

Collection methods:

Related metadata: is an alternative to Number of contacts (psychiatric outpatient clinic/day program) vers 1

relates to the data element concept Service contact vers 1

is derived from Service contact date vers 1

Administrative Attributes

Source document:

Source organisation: National Mental Health Information Strategy Committee

Information model link:

NHIM Service provision event

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

Comments:

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

Identifying and Definitional Attributes

Knowledgebase ID: ***000641*** ***Version No: 2***

Metadata type: Derived Data Element

Admin. status: Current

01/07/02

Definition: Number of service contacts recorded between a client and the service provider within a treatment episode for the purpose of providing alcohol and other drug treatment.

Context: Alcohol and other drug treatment services:

This data element provides a measure of the frequency of client contact and service utilisation within a treatment episode.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNN

Minimum size: 1

Maximum size: 3

Data domain: Count of service contacts

Guide for use: This data element is a count of service contacts related to treatment, that are recorded on a client record. Any client contact that does not constitute part of a treatment should not be considered a service contact. Contact with the client for administrative purposes, such as arranging an appointment, should not be included.

This data element is not collected for residential clients.

Where multiple service provider staff have contact with the client at the same time, on the same occasion of service, the contact is counted only once.

When multiple service contacts are recorded on the same day, each independent contact should be counted separately.

Verification rules:

Collection methods: To be collated at the close 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 concept Commencement of treatment episode for alcohol and other drugs vers 2

supersedes previous data element Number of service contacts within a treatment episode for alcohol and other drugs vers 1

relates to the data element concept Service contact vers 1

relates to the data element concept Treatment episode for alcohol and other drugs vers 1

Administrative Attributes

Source document:

Source organisation: Intergovernmental Committee on Drugs NMDS WG

Information model link:

NHIM Service provision event

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

Comments:

Nursing diagnosis

Identifying and Definitional Attributes

Knowledgebase ID: ***000110*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/98

Definition: Nursing diagnosis is a clinical judgement about individual, family or community responses to actual or potential health problems/life processes. Nursing diagnoses provide the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable.

Context: Enables analysis of information by diagnostic variables especially in relation to the development of outcome information, Goal of care and Nursing intervention. Nursing diagnosis and the data element Nursing interventions have shown to be more predictive of resource use than client's functional status or medical diagnosis.

Relational and Representational Attributes

Datatype: Alphanumeric

Representational form: Code

Representational layout: N.N.N.N.N.N

Minimum size: 3

Maximum size: 11

Data domain: The North American Nursing Diagnosis Association (NANDA) Taxonomy, 1997–1998

Guide for use: Up to seven nursing diagnoses may be nominated, according to the following:

1. Nursing diagnosis most related to the principal reason for admission (one only)

2–6. Other nursing diagnoses of relevance to the current episode.

The NANDA codes should be used in conjunction with a nursing diagnosis text. The NANDA coding structure is a standard format for reporting nursing diagnosis. It is not intended in any way to change or intrude upon nursing practice, provided the information available can transpose to the NANDA codes for the Community Nursing Minimum Data Set – Australia (CNMDSA).

Verification rules:

Collection methods: In considering how nursing diagnosis could be implemented, agencies may opt to introduce systems transparent to the clinician if there is confidence that a direct and reliable transfer to NANDA codes can be made from information already in place.

Agencies implementing new information systems should consider the extent to which these can facilitate practice and at the same time lighten the burden of documentation. Direct incorporation of the codeset or automated mapping to it when the information is at a more detailed level are equally valid and viable options.

Related metadata: relates to the data element Goal of care vers 2

relates to the data element Nursing interventions vers 2

Administrative Attributes

Source document: NANDA Nursing Diagnoses: Definitions and Classification 1997–1998. (1997) North American Nursing Diagnosis Association.

Source organisation: Australian Council of Community Nursing Services

Information model link:

NHIM Physical wellbeing

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

Comments: The CNMDSA Steering Committee considered information from users of the data in relation to Nursing diagnosis. Many users have found the taxonomy wanting in its ability to describe the full range of persons and conditions seen by community nurses in the Australian setting. In the absence of an alternative taxonomy with wide acceptance, the CNMDSA Steering Committee has decided to retain NANDA. The University of Iowa has a written agreement with NANDA to expand the relevance of NANDA. The Australian Council of Community Nursing Services (ACCNS) has sought collaboration with a US project at the University of Iowa which is seeking to refine, extend, validate and classify the NANDA taxonomy.

Nursing interventions

Identifying and Definitional Attributes

Knowledgebase ID: ***000112*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/98

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

Context: To enable analysis of the interventions within an episode of care, in relation to the outcome of this care, especially when linked with information on the diagnosis and goals. The recording of Nursing interventions is critical information for health service monitoring and planning. It is a major descriptor of the care provided throughout an episode.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1 Coordination and collaboration of care
2 Supporting informal carers
3 General nursing care
4 Technical nursing treatment or procedure
5 Counselling and emotional support
6 Teaching/education
7 Monitoring and surveillance
8 Formal case management
9 Service needs assessment only

Guide for use: For the purposes of the Community Nursing Minimum Data Set – Australia (CNMDSA), the interventions are not necessarily linked to each nursing problem, nor are they specific tasks, but rather, broader-level intervention categories focusing on the major areas of a person's need. These summary categories subsume a range of specific actions or tasks. The following definitions are to assist in coding:

1 Coordination and collaboration of care:

occurs when there are multiple care deliverers. The goal of coordination and collaboration is the efficient, appropriate integrated delivery of care to the person. Tasks which may be involved include: liaison, advocacy, planning, referral, information and supportive discussion and/or education. Although similar in nature to formal case management this intervention is not the one formally recognised by specific funding (see Code 8).

2 Supporting information carers:

includes activities, which the nurse undertakes to assist the carer in the delivery of the carer's role. This does not include care given directly to the

person. Examples of tasks involved in supporting the carer include: counselling, teaching, informing, advocacy, coordinating, and grief or bereavement support.

3 General nursing care:

includes a broad range of activities, which the nurse performs to directly assist the person; in many cases, this assistance will focus on activities of daily living. This assistance will help a person whose health status, level of dependency, and/or therapeutic needs are such that nursing skills are required. Examples of tasks include: assistance with washing, grooming and maintaining hygiene, dressing, pressure area care, assistance with toileting, bladder and bowel care, assistance with mobility and therapeutic exercise, attention to physical comfort and maintaining a therapeutic environment.

4 Technical nursing treatment or procedure:

refers to technical tasks and procedures for which nurses receive specific training and which require nursing knowledge of expected therapeutic effect, possible side-effects, complications and appropriate actions related to each. Some examples of technical care activities are: medication administration (including injections), dressings and other procedures, venipuncture, monitoring of dialysis, and implementation of pain management technology.

5 Counselling and emotional support:

focuses on non-physical care given to the person, which aims to address the affective, psychological and/or social needs. Examples of these include: bereavement, well being, decision-making support and values-clarification.

6 Teaching/education:

refers to providing information and/or instruction about a specific body of knowledge and/or procedure, which is relevant to the person's situation. Examples of teaching areas include: disease process, technical procedure, health maintenance, health promotion and techniques for coping with a disability.

7 Monitoring and surveillance:

refers to any action by which the nurse evaluates and monitors physical, behavioural, social and emotional responses to disease, injury, and nursing or medical interventions.

8 Formal case management:

refers to the specific formal service, which is funded to provide case management for a person. Note that coordination and collaboration of care (Code 1) is not the same as Formal Case Management.

9 Service needs assessment only:

is assessment of the person when this is the only activity carried out and no further nursing care is given; for example, assessment for ongoing care and/or inappropriate referrals. Selection of this option means that no other intervention may be nominated. Thus, if an assessment for the Domiciliary Care Benefit is the reason for a visit, but other interventions such as, counselling and support; coordination/collaboration of care are carried out, then the Assessment only is not an appropriate code.

Verification rules: Up to eight codes may be selected. If Code 9 is selected no other nursing interventions are collected. If Code 9 is selected then code 7 in Goal of care must also be selected.

Collection methods: Collect on continuing basis throughout the episode in the event of data collection that occurs prior to discharge. Up to eight codes may be collected. Within a computerised information system the detailed activities can be mapped to the CNMDSA interventions enabling the option of a rich level of detail of activities or summarised information.

Related metadata: relates to the data element Nursing diagnosis vers 2

relates to the data element Goal of care vers 2

supersedes previous data element Nursing interventions vers 1

Administrative Attributes

Source document:

Source organisation: Australian Council of Community Nursing Services

Information model link:

NHIM Service provision event

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

Comments: The CNMDSA Nursing interventions are summary information overlying the detailed nursing activity usually included in an agency data collection. They are not intended as a description of nursing activities in the CNMDSA. For instance, Technical nursing treatment or Procedure is the generic term for a broad range of nursing activities such as medication administration and wound care management.

Collection of this information at discharge carries with it the expectation that nursing records will lend themselves to this level of summarisation of the care episode. The selection of eight interventions if more are specified is a potentially subjective task unless the nursing record is structured and clear enough to enable such a selection against the reasons for admission to care, and the major focus of care delivery. Clearly, the task is easier if ongoing automated recording of interventions within an agency information system enables discharge reporting of all interventions and their frequency, over a care episode.

Those agencies providing allied health services may wish to use the Physiotherapy and Occupational Therapy Interventions developed in conjunction with the National Centre for Classification in Health in addition to the CNMDSA Nursing interventions or other more relevant code sets.

Occasions of service

Identifying and Definitional Attributes

Knowledgebase ID: ***000209*** ***Version No: 1***

Metadata type: Derived Data Element

Admin. status: Current

01/07/89

Definition: The number of occasions of examination, consultation, treatment or other service provided to a patient in each functional unit of a health service establishment. Each diagnostic test or simultaneous set of related diagnostic tests for the one patient referred to a hospital pathology department consists of one occasion of service.

Context: Occasions of service are required as a measure of non-admitted patient service provision.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNNNNNN

Minimum size: 1

Maximum size: 7

Data domain: Count of the number of occasions of service

Guide for use:

Verification rules:

Collection methods: The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average Diagnosis Related Group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a separation is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Related metadata:

Administrative Attributes

Source document:

Source organisation: National minimum data set working parties

Information model link:

NHIM Performance indicator

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

Comments:

Occupation of person

Identifying and Definitional Attributes

Knowledgebase ID: ***000230*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/99

Definition: The current job or duties in which the person is principally engaged.

Context: Injury surveillance:

There is considerable user demand for data on occupation-related injury and illness, including from Worksafe Australia and from industry, where unnecessary production costs are known in some areas and suspected to be related to others in work-related illness, injury and disability.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NN

Minimum size: 2

Maximum size: 2

Data domain: Valid code from Australian Standard Classification of Occupations, Second edition (Australian Bureau of Statistics 1997, Catalogue No. 1220.0 – 2-digit code level (sub-major group)

Guide for use:

Verification rules:

Collection methods:

Related metadata: supersedes previous data element Occupation of person vers 1

Administrative Attributes

Source document: Australian Standard Classification of Occupations, Second Edition, 1997, Australian Bureau of Statistics, Catalogue No. 1220.0

Source organisation: Australian Bureau of Statistics

Information model link:

NHIM Labour characteristic

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

Comments: The structure of the Australian Standard Classification of Occupations has five levels:

9 Major groups 1-digit codes

35 Sub-major groups 2-digit codes

81 Minor groups 3-digit codes

340 Unit groups 4-digit codes

986 Occupations 5-digit codes

For example:

Level	Code	Title
Major group	2	Professionals
Sub-major group	23	Health professionals
Minor group	231	Medical practitioners
Unit group	2311	Generalist medical practitioners
Occupation	2311-11	General medical practitioner

A Computer Assisted Coding system is available from the Australian Bureau of Statistics to assist in coding occupational data to Australian Standard Classification of Occupations codes.

Onset of labour

Identifying and Definitional Attributes

Knowledgebase ID: ***000113*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/00

Definition: Manner in which labour started.

Context: Perinatal care:

How labour commenced is closely associated with method of birth and maternal and neonatal morbidity. Induction rates vary for maternal risk factors and obstetric complications and are important indicators of obstetric intervention.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1 Spontaneous

2 Induced

3 No labour

4 Not stated

Guide for use: Labour commences at the onset of regular uterine contractions, which act to produce progressive cervical dilatation, and is distinct from spurious labour or pre-labour rupture of membranes.

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

Collection methods: If prostaglandins were given to induce labour and there is no resulting labour until after 24 hours, then code the onset of labour as spontaneous.

Related metadata:

is used in conjunction with Method of birth vers 1

supersedes previous data element Onset of labour vers 1

is used in conjunction with Type of labour induction 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***
NMDS – Perinatal	01/07/2000	

Comments:

Ophthalmological assessment – outcome

Identifying and Definitional Attributes

Knowledgebase ID: ***000837*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: The result of an ophthalmological assessment done during the last 12 months.

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 Normal
2 Diabetes abnormality
3 Non-diabetes abnormality
4 Not visualised
9 Not stated/inadequately described

Guide for use: This is a repeating record of both eyes.

1st field – Right retina

2nd field – Left retina

Record the result of the fundus examination for each eye as: Normal/ Diabetes abnormality/ Non-diabetes abnormality/or Not visualised.

Examples:

- code 12 for right retina Normal and left retina Diabetes abnormality.
- code 32 for right retina Non-diabetes abnormality and left retina Diabetes abnormality.

Only the result of an assessment carried out in the last 12 months should be recorded.

Verification rules:

Collection methods: Ophthalmological assessment should be performed by an ophthalmologist or a suitably trained clinician.

A comprehensive ophthalmological examination includes:

- Checking visual acuity with Snellen chart – correct with pinhole if indicated
- Examination for cataract
- Examination of fundi with pupils dilated.

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

relates to the data element Blindness – diabetes complication vers 1

relates to the data element Cataract – history vers 1

relates to the data element Ophthalmoscopy – performed vers 1

relates to the data element Referred to ophthalmologist – diabetes mellitus vers 1

relates to the data element Visual acuity 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:	***Start date***	***End date***
DSS – Diabetes (clinical)	01/01/2003	

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

Many diabetes eye-related problems are asymptomatic and require appropriate eye assessment to be detected. Regular eye checkup is important for patients suffering from diabetes mellitus. This helps to early detect abnormalities and to avoid or postpone complications and prevent blindness in people with diabetes.

According to Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus a comprehensive ophthalmological examination should be carried out:

- at diagnosis and then every 1–2 years for patients whose diabetes onset was at age 30 years or more
- within five years of diagnosis and then every 1–2 years for patients whose diabetes onset was at age less than 30 years.

Assessment by an ophthalmologist is essential:

- at initial examination if the corrected visual acuity is less than 6/6 in either eye
- at subsequent examinations if declining visual acuity is detected
- if any retinal abnormality is detected
- if clear view of retina is not obtained.

References:

Vision Australia, No 2, 1997/8; University of Melbourne.

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

US National Eye Institute.

Ophthalmoscopy – performed

Identifying and Definitional Attributes

Knowledgebase ID: ***000838*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/01/03

Definition: Whether or not an examination of the fundus of the eye by an ophthalmologist or optometrist as a part of the ophthalmological assessment has been undertaken.

Context: Public health, health care and clinical settings.

Relational and Representational Attributes

Datatype: Numeric

Representational form:

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1 Yes, ophthalmoscopy performed

2 No, ophthalmoscopy not performed

9 Not stated/inadequately described

Guide for use: Record whether or not a fundus examination of the eye has occurred.

Verification rules:

Collection methods: Ask the individual if he/she has undertaken an eye check, including examination of fundi with pupils dilated. Pupil dilatation and an adequate magnified view of the fundus is essential, using either detailed direct or indirect ophthalmoscopy or fundus camera. This will usually necessitate referral to an ophthalmologist.

Related metadata:

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

relates to the data element Blindness – diabetes complication vers 1

relates to the data element Cataract – history vers 1

relates to the data element Ophthalmological assessment – outcome vers 1

relates to the data element Referred to ophthalmologist – diabetes mellitus vers 1

relates to the data element Visual acuity vers 1

Administrative Attributes

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

Source organisation: National Diabetes Data Working Group

Information model link:

NHIM Request for/entry into service event

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

Comments:

When reporting:

- Record whether or not an examination of the fundus of the eye by an ophthalmologist or optometrist as a part of the ophthalmological assessment has been undertaken in the last 12 months.

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

Eye examinations should be commenced at the time diabetes is diagnosed. If no retinopathy is present, repeat the eye examination at least every 2 years. Once retinopathy is identified more frequent observation is required.

Diabetic retinopathy is a leading cause of blindness. Retinopathy is characterised by proliferation of the retina's blood vessels, which may project into the vitreous, causing vitreous haemorrhage, proliferation of fibrous tissue and retinal detachment. It is often accompanied by microaneurysms and macular oedema, which can express as a blurred vision. The prevalence of retinopathy increases with increasing duration of diabetes. In the early stage, retinopathy is asymptomatic, however up to 20% of people with diabetes Type 2 have retinopathy at the time of diagnosis of diabetes. Cataract and glaucoma are also associated diabetic eye problems that could lead to blindness.

Regular eye checkups are important for patients suffering from diabetes mellitus. This helps to detect and treat abnormalities early and to avoid or postpone vision-threatening complications.

References:

Vision Australia, No. 2 – 1997/8; University of Melbourne.

Diabetes: complications: Therapeutic Guidelines Limited (05.04.2002).

Organ procurement – posthumous

Identifying and Definitional Attributes

Knowledgebase ID: ***000441*** ***Version No: 1***

Metadata type: Data Element Concept

Admin. status: Current

01/07/00

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

Context: Hospital activity.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

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

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

Verification rules:

Collection methods:

Related metadata:

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Service provision event

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

Comments:

Other drug of concern

Identifying and Definitional Attributes

Knowledgebase ID: ***000442*** ***Version No: 2***

Metadata type: Data Element

Admin. status: Current

01/07/03

Definition: A drug apart from the Principal drug of concern which the client states as being a concern.

Context: Alcohol and other drug treatment services:

This item complements Principal drug of concern. The existence of other drugs of concern may have a role in determining the types of treatment required and may also influence treatment outcomes.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: NNNN

Minimum size: 4

Maximum size: 4

Data domain: The Australian Standard Classification of Drugs of Concern, Australian Bureau of Statistics, Cat. No. 1248.0 (2000).

Guide for use: Record each additional drug of concern (according to the client) relevant to the treatment episode. The other drug of concern does not need to be linked to a specific treatment type.

Verification rules: There should be no duplication with Principal drug of concern.

Collection methods: More than one drug may be selected.

Any other drug of concern for the client should be recorded upon commencement of a 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

supersedes previous data element Other drugs of concern vers 1

relates to the data element Other treatment type for alcohol and other drugs vers 1

relates to the data element Principal drug of concern vers 2

Administrative Attributes

Source document:

Source organisation: Intergovernmental Committee on Drugs NMDS WG

Information model link:

NHIM Physical wellbeing

Data Set Specifications:	***Start date***	***End date***
NMDS – Alcohol and other drug treatment services	01/07/2003	

Comments:

Other recurrent expenditure

Identifying and Definitional Attributes

Knowledgebase ID: ***000247*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/89

Definition: Other payments are all other recurrent expenditure not included elsewhere in any of the recurrent expenditure categories. Gross expenditure should be reported with no revenue offsets (except for inter-hospital transfers).

Context: Health expenditure:

This category is required for balancing purposes and to capture all those additional expenditures which can be significant in aggregate.

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:

Other revenues

Identifying and Definitional Attributes

Knowledgebase ID: ***000323*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/89

Definition: All other revenue received by the establishment that is not included under patient revenue or recoveries (but not including revenue payments received from State or Territory governments). This would include revenue such as investment income from temporarily surplus funds and income from charities, bequests and accommodation provided to visitors.

See text relating to offsetting practices. Gross revenue should be reported (except in relation to payments for inter-hospital transfers of goods and services).

Context: Health services:

In aggregate, other revenues as defined above constitute a significant source of income for many establishments and are necessary to complete the revenue picture for health financing studies or analyses 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 Health Data Committee

Information model link:

NHIM Financial resource item

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

Comments:

Other treatment type for alcohol and other drugs

Identifying and Definitional Attributes

Knowledgebase ID: **000642** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/01

Definition: All other forms of treatment provided to the client in addition to the data element Main treatment type for alcohol and other drugs.

Context: Alcohol and other drug treatment services:

Information about treatment provided is of fundamental importance to service delivery and planning.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1 Withdrawal management (detoxification)

2 Counselling

3 Rehabilitation

4 Pharmacotherapy

5 Other

Guide for use: To be completed at cessation of treatment episode.

Only report treatment recorded in the client's file that is in addition to, and not a component of, the Main treatment type for alcohol and other drugs. Treatment activity reported here is not necessarily for Principal drug of concern in that it may be treatment for a Other drug of concern.

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

Code 2 refers to any method of individual or group counselling directed towards identified problems with alcohol and/or other drug use or dependency. This selection excludes counselling activity that is part of a rehabilitation program as defined in code 3.

Code 3 refers to an intensive treatment program that integrates a range of services and therapeutic activities that may include behavioural treatment approaches, recreational activities, social and community living skills, group work and relapse prevention. Rehabilitation treatment can provide a high level of support (i.e. up to 24 hours a day) and tends towards a medium to longer-term duration. Rehabilitation activities can occur in residential or non/residential settings.

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

Verification rules:

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

Related metadata: relates to the data element Main treatment type for alcohol and other drugs 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:	***Start date***	***End date***
NMDS – Alcohol and other drug treatment services	01/07/2001	

Comments:

Outcome of last previous pregnancy

Identifying and Definitional Attributes

Knowledgebase ID: ***000114*** ***Version No: 1***

Metadata type: Data Element

Admin. status: Current

01/07/96

Definition: Outcome of the most recent pregnancy preceding this pregnancy.

Context: Perinatal statistics:

Adverse outcome in previous pregnancy is an important risk factor for subsequent pregnancy.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1 Single live birth – survived at least 28 days

2 Single live birth – neonatal death (within 28 days)

3 Single stillbirth

4 Spontaneous abortion

5 Induced abortion

6 Ectopic pregnancy

7 Multiple live birth – all survived at least 28 days

8 Multiple birth – one or more neonatal deaths (within 28 days) or stillbirths

Guide for use: In the case of multiple pregnancy with foetal loss before 20 weeks, code on outcome of surviving foetus(es) beyond 20 weeks.

Verification rules:

Collection methods:

Related metadata: is a qualifier of Date of completion 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: This data item is recommended by the World Health Organization. It is collected in some States and Territories.

Overdue patient

Identifying and Definitional Attributes

Knowledgebase ID:	***000085***	***Version No: 3***
Metadata type:	Derived Data Element	
Admin. status:	Current	
	01/07/97	

Definition: An overdue patient is one whose wait has exceeded the time that has been determined as clinically desirable in relation to the urgency category to which they have been assigned.

Context: Elective surgery:

The numbers and proportions of overdue patients represent a measure of the hospital's performance in provision of elective hospital care.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1 Overdue patient

2 Other

Guide for use: This data element is only required for patients in clinical urgency categories with specified maximum desirable waiting times. Overdue patients are those for whom the hospital system has failed to provide timely care and whose wait may have an adverse effect on the outcome of their care. They are identified by a comparison of Waiting time at removal from elective surgery waiting list or Waiting time at a census date and the maximum desirable time limit for the Clinical urgency classification.

A patient is classified as overdue if ready for care and Waiting time at removal from elective surgery waiting list or Waiting time at a census date is longer than 30 days for patients in Clinical urgency category 1 or 90 days for patients in Clinical urgency category 2.

Verification rules:

Collection methods:

Related metadata:

is qualified by Clinical urgency vers 2

supersedes previous data element Overdue patient vers 2

is derived from Waiting time at a census date vers 2

is derived from Waiting time at removal from elective surgery waiting list vers 2

is derived from Waiting time at removal from elective surgery waiting list vers 2

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Performance indicator

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

Comments: This data item is not used for patients in Clinical urgency category 3 as there is no specified timeframe within which it is desirable that they are admitted. The data element Extended wait patient identifies patients in Clinical urgency category 3 who have waited longer than one year at admission or at the time of a census.

Overnight-stay patient

Identifying and Definitional Attributes

Knowledgebase ID: ***000116*** ***Version No: 3***

Metadata type: Data Element Concept

Admin. status: Current

01/07/01

Definition: A patient who, following a clinical decision, receives hospital treatment for a minimum of one night, i.e. who is admitted to and separated from the hospital on different dates.

Context: Admitted patient care.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use: An overnight-stay patient in one hospital cannot be concurrently an overnight-stay patient in another hospital, unless they are receiving contracted care. If not under a hospital contract, a patient must be separated from one hospital and admitted to the other hospital on each occasion of transfer.

An overnight-stay patient of a hospital (originating hospital) who attends another hospital (the destination hospital) on a contracted basis is to be regarded by the originating hospital as an overnight-stay patient, as if the patient had not left for contracted hospital care.

Treatment provided to an intended same-day patient who is subsequently classified as an overnight-stay patient is regarded as part of the overnight episode.

A non-admitted (emergency/outpatient) service provided to a patient who is subsequently classified as an admitted patient shall be regarded as part of the admitted episode. Any occasion of service should be recorded and identified as part of the admitted patient's episode of care.

Patients who leave of their own accord, die or are transferred on their first day in hospital are not overnight-stay patients.

Verification rules:

Collection methods:

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

supersedes previous data element Overnight-stay patient vers 2

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Recipient role

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

Comments: