

Data Elements

S – T

Salaries and wages

Identifying and Definitional Attributes

Knowledgebase ID:	000254	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/89	
Definition:	<p>Salary and wage payments for all employees of the establishment (including contract staff employed by an agency, provided staffing (ME) data is also available). This is to include all paid leave (recreation, sick and long-service) and salary and wage payments relating to workers compensation leave for the following staffing categories (see below).</p> <p>Generally, salary data by staffing categories should be broadly consistent with full-time equivalent staffing numbers. Where staff provide services to more than one hospital, their salaries should be apportioned between all hospitals to whom services are provided on the basis of hours worked in each hospital.</p> <p>Salary payments for contract staff employed through an agency should be included under salaries for the appropriate staff category provided they are included in full-time equivalent staffing. If they are not salary, payments should be shown separately.</p>	
Context:	<p>Health expenditure:</p> <p>Salaries and wages invariably constitute the major component of recurrent and, indeed, total expenditure for the establishments forming part of this data set and are vital to any analysis of health expenditure at the national level. The categories correspond with those relating to full-time equivalent staffing which is a requirement for any proper analysis of average salary costs.</p>	

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Currency
Representational layout:	\$999,999,999
Minimum size:	2
Maximum size:	12
Data domain:	Australian dollars. Rounded to nearest whole dollar.
Guide for use:	<p>Record as currency up to hundreds of millions of dollars.</p> <p>Figures should be supplied for each of the staffing categories:</p> <ul style="list-style-type: none"> C1.1 Salaried medical officers C1.2 Registered nurses C1.3 Enrolled nurses C1.4 Student nurses C1.5 Trainee/pupil nurses C1.6 Other personal care staff C1.7 Diagnostic and health professionals C1.8 Administrative and clerical staff C1.9 Domestic and other staff

Verification rules:

Collection methods: For contract staff, see comments under the data element Total full-time equivalent staff. Salary data for contract staff, provided the contract is for the supply of labour (e.g. nursing) rather than products (e.g. photocopier maintenance), should be shown under the appropriate staff salary category provided that corresponding staffing (full-time equivalent) data is available. If not, it should be shown separately.

Related metadata: relates to the data element Establishment type vers 1
relates to the data element Full-time equivalent staff vers 2

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	
NMDS - Community mental health establishments	01/07/1998	

Comments:

Same-day patient

Identifying and Definitional Attributes

Knowledgebase ID: 000146 **Version No:** 1

Metadata type: Data Element Concept

Admin. status: Current
01/07/94

Definition: A same-day patient is a patient who is admitted and separates on the same date, and who meets one of the following minimum criteria:

- that the patient receive same-day surgical and diagnostic services as specified in bands 1A, 1B, 2, 3, and 4 but excluding uncertified type C Professional Attention Procedures within the Health Insurance Basic Table as defined in s.4 (1) of the *National Health Act 1953* (Commonwealth)
- that the patient receive type C Professional Attention Procedures as specified in the Health Insurance Basic Table as defined in s.4 (1) of the *National Health Act 1953* (Commonwealth) with accompanying certification from a medical practitioner that an admission was necessary on the grounds of the medical condition of the patient or other special circumstances that relate to the patient.

Context: Admitted patient care.

Relational and Representational Attributes

Datatype:

Representational form:

Representational layout:

Minimum size:

Maximum size:

Data domain:

Guide for use: Same-day patients may be either intended to be separated on the same day, or intended overnight-stay patients who left of their own accord, died or were transferred on their first day in the hospital.

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

Non-admitted (emergency or outpatient) services 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.

Data on same-day patients are derived by a review of admission and separation dates.

Verification rules:

Collection methods:

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

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Recipient role

Data Set Specifications:

Start date

End date

Comments:

Scheduled admission date

Identifying and Definitional Attributes

Knowledgebase ID:	000147	Version No: 2
Metadata type:	Data Element	
Admin. status:	Current	
	01/01/95	
Definition:	The date on which it is proposed that a patient on the waiting list will be admitted for an episode of care.	
Context:	This item is required for the purposes of hospital management - allocation of beds, operating theatre time and other resources.	

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Date
Representational layout:	DDMMYYYY
Minimum size:	8
Maximum size:	8
Data domain:	Valid dates
Guide for use:	
Verification rules:	
Collection methods:	
Related metadata:	is used in conjunction with Listing date for care vers 4 supersedes previous data element Scheduled admission date vers 1

Administrative Attributes

Source document:		
Source organisation:	National Health Data Committee	
Information model link:		
	NHIM Planning event	
Data Set Specifications:	Start date	End date
Comments:	If this data element were to be used to compare different hospitals or geographical locations, it would be necessary to specify when the scheduled date is to be allocated (for example, on addition to the waiting list).	

Separation

Identifying and Definitional Attributes

Knowledgebase ID:	000148	Version No: 3
Metadata type:	Data Element Concept	
Admin. status:	Current	
	01/07/00	
Definition:	Separation is the process by which an episode of care for an admitted patient ceases. A separation may be formal or statistical.	
	Formal separation:	
	The administrative process by which a hospital records the cessation of treatment and/or care and/or accommodation of a patient.	
	Statistical separation:	
	The administrative process by which a hospital records the cessation of an episode of care for a patient within the one hospital stay.	
Context:	Admitted patient care.	

Relational and Representational Attributes

Datatype:	
Representational form:	
Representational layout:	
Minimum size:	
Maximum size:	
Data domain:	
Guide for use:	This treatment and/or care provided to a patient prior to separation occurs over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients).
Verification rules:	
Collection methods:	
Related metadata:	<ul style="list-style-type: none"> relates to the data element concept Admission vers 3 relates to the data element concept Admitted patient vers 3 relates to the data element Care type vers 4 supersedes previous data element Separation vers 2 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

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

Separation date

Identifying and Definitional Attributes

Knowledgebase ID:	000043	Version No: 5
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/99	
Definition:	Date on which an admitted patient completes an episode of care.	
Context:	Required to identify the period in which an admitted patient hospital stay or episode occurred, and for derivation of length of stay.	

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Date
Representational layout:	DDMMYYYY
Minimum size:	8
Maximum size:	8
Data domain:	Valid dates
Guide for use:	
Verification rules:	For the provision of State and Territory hospital data to Commonwealth agencies this field must: <ul style="list-style-type: none"> - be <= last day of financial year - be >= first day of financial year - be >= Admission date.
Collection methods:	
Related metadata:	supersedes previous data element Discharge date vers 4 is used in the calculation of Length of stay (including leave days) vers 1 is used in the calculation of Length of stay (postnatal) vers 1

Administrative Attributes

Source document:		
Source organisation:	National Health Data Committee	
Information model link:		
NHIM	Exit/leave from service event	
Data Set Specifications:		
NMDS - Admitted patient care	Start date	End date
	01/07/1999	
NMDS - Admitted patient mental health care	01/07/1999	
NMDS - Perinatal	01/07/1999	
NMDS - Admitted patient palliative care	01/07/1999	

Comments:

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

Separation time

Identifying and Definitional Attributes

Knowledgebase ID:	000644	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/01	
Definition:	Time at which an admitted patient completes an episode of care.	
Context:	Admitted patient care.	

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Time
Representational layout:	HHMM
Minimum size:	4
Maximum size:	4
Data domain:	24-hour clock time at separation
Guide for use:	
Verification rules:	
Collection methods:	
Related metadata:	<ul style="list-style-type: none"> relates to the data element concept Admission vers 3 relates to the data element Admission date vers 4 relates to the data element Admission time vers 2 relates to the data element concept Admitted patient vers 3 relates to the data element Separation date vers 5

Administrative Attributes

Source document:		
Source organisation:		
Information model link:		
NHIM	Exit/leave from service event	
Data Set Specifications:	Start date	End date
Comments:	Required to identify the time of completion of the episode or hospital stay, for calculation of length of stay.	

Separations

Identifying and Definitional Attributes

Knowledgebase ID:	000205	Version No:	2
Metadata type:	Derived Data Element		
Admin. status:	Current		
	01/07/94		
Definition:	The total number of separations occurring during the reference period. This includes both formal and statistical separations.		
Context:	Admitted patient care: Needed as the basic count of the number of separations from care for an establishment.		

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	NNNNNN
Minimum size:	1
Maximum size:	6

Data domain: A number, representing the number of completed episodes of care.

Guide for use: The sum of the number of separations where the Discharge date has a value:

- >= the beginning of the reference period (typically a financial year)
- <= the end of the reference period.

This sum may be calculated at:

- individual establishment level or
- system (i.e. State/Territory) level, i.e. the sum of the number of establishments.

Verification rules:

Collection methods:

Related metadata: relates to the data element concept Separation vers 3
is derived from Separation date vers 5
supersedes previous derived data element Separations 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
NMDS - Community mental health establishments	01/07/1998	
NMDS - Public hospital establishments	01/07/1994	

Comments:

Service contact

Identifying and Definitional Attributes

Knowledgebase ID: 000401 **Version No:** 1

Metadata type: Data Element Concept

Admin. status: Current
01/07/99

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

Context: Identifies service delivery at the patient level for mental health services (including consultation/liason, mobile and outreach services).
A service contact can include either face-to-face, telephone or video link service delivery modes. Service contacts would either be with a client, carer or family member or another professional or mental health worker involved in providing care and do not include contacts of an administrative nature (e.g. telephone contact to schedule an appointment) except where a matter would need to be noted on a patient's record.
Service contacts may be differentiated from administrative and other types of contacts by the need to record data in the client record. However, there may be instances where notes are made in the client record that have not been prompted by a service contact with a patient/client (e.g. noting receipt of test results that require no further action). These instances would not be regarded as a service contact.

Relational and Representational Attributes

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 Number of service contact dates vers 2
relates to the data element Service contact date vers 1

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Service provision event

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

Comments: The proposed definition is not able to measure case complexity or level of resource usage with each service contact alone. This limitation also applies to the concept of occasions of service (in admitted patient care) and hospital separations. The National Health Data Committee also acknowledges that information about group sessions or activities that do not result in a dated entry

being made in each individual participant's patient/client record is not currently covered by this data element concept.

Service contact date

Identifying and Definitional Attributes

Knowledgebase ID:	000402	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/99	
Definition:	The date of each service contact between a health service provider and patient/client.	
Context:	Community-based mental health care and clinical settings: The service contact is required for clinical audit and other quality assurance purposes. NMDS – Community mental health care: Collection of the date of each service contact with health service providers allows a description or profile of service utilisation by a person or persons during an episode of care.	

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Date
Representational layout:	DDMMYYYY
Minimum size:	8
Maximum size:	8
Data domain:	Valid date
Guide for use:	Requires services to record the date of each service contact, including the same date where multiple visits are made on one day (except where the visits may be regarded as a continuation of the one service contact). Where an individual patient/client participates in a group activity, a service contact date is recorded if the person's participation in the group activity results in a dated entry being made in the patient's/client's record.
Verification rules:	
Collection methods:	For collection from community-based (ambulatory and non-residential) agencies.
Related metadata:	is used in the derivation of Number of service contact dates vers 2 relates to the data element concept Service contact vers 1

Administrative Attributes

Source document:		
Source organisation:		
Information model link:		
NHIM	Service provision event	
Data Set Specifications:		Start date End date
NMDS – Community mental health care		01/07/2000
DSS – Cardiovascular disease (clinical)		01/01/2003

DSS - Diabetes (clinical)

01/01/2003

Comments:

NMDS - Community mental health care:

The National Health Data Committee acknowledges that information about group sessions or activities that do not result in a dated entry being made in each individual participant's patient/client record is not obtained via this data element.

Service delivery outlet

Identifying and Definitional Attributes

Knowledgebase ID:	000845	Version No: 1
Metadata type:	Data Element Concept	
Admin. status:	Current	
	01/07/03	
Definition:	A site from which an organisation, or sub-unit of an organisation, delivers a health/community service.	
Context:	Alcohol and other drug treatment services: Required to identify the agency sites that conduct treatment episodes, as distinguished from administration centres. Identification of sites from which health care or community services are delivered facilitates assessment of the accessibility of services to the population.	

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 Establishment identifier vers 4 relates to the data element Geographical location of service delivery outlet vers 1 relates to the data element Treatment delivery setting for alcohol and other drugs vers 1

Administrative Attributes

Source document:			
Source organisation:	Intergovernmental Committee on Drugs NMDS WG		
Information model link:	NHIM Service delivery setting		
Data Set Specifications:		Start date	End date

Comments:	An organisation may have one or more service delivery outlets. An organisation with a devolved structure for service delivery may or may not devolve all functions to the service delivery outlet level. It is common for administrative functions, including personnel management, to be retained at a higher or central level of an organisation. The service delivery outlet is the lowest level of an organisation at which, or from which, services are delivered. The site from which a service is delivered relates to the physical location of the service and is to be clearly differentiated from the service delivery setting which refers to the
------------------	--

type of physical setting in which a service is actually provided to a client (e.g. client's home, non-residential treatment facility etc.).

For example, where a service provider regularly delivers a service at a variety of clients' homes (e.g. home visits every Monday, Wednesday and Friday) or a mobile service delivers a service to a variety of different locations, then the service delivery outlet should be recorded as the location of the clinic in which the service provider is based. However, where a mobile unit regularly (e.g. every Monday) delivers a service from the same geographical location then this location will be recorded as the service delivery outlet.

Sex

Identifying and Definitional Attributes

Knowledgebase ID:	000149	Version No: 3
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/03	
Definition:	The sex of the person.	
Context:	Required for analyses of service utilisation, needs for services and epidemiological studies.	

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	N
Minimum size:	1
Maximum size:	1
Data domain:	<ul style="list-style-type: none"> 1 Male 2 Female 3 Indeterminate 9 Not stated/inadequately described

Guide for use: An indeterminate sex category may be necessary for situations such as the classification of perinatal statistics when it is not possible for the sex to be determined.

Verification rules: Code 3 Indeterminate should be queried for people aged 90 days (3 months) or greater.
For the provision of State and Territory hospital data to Commonwealth agencies this field must be consistent with diagnosis and procedure codes, for records grouped in Major diagnostic categories 12, 13 and 14, for valid grouping. For other Major diagnostic categories, sex conflicts should be queried.

Collection methods: Code 9 is not to be an allowable option when data is being collected ie it is not to be a tick box on any collection forms or computer screens. Systems are to take account of any null values that may occur on the primary collection form. It is suggested that the following format be used for data collection:

What is your (the person's) sex?

___ Male ___ Female

The term 'sex' refers to the biological differences between males and females, while the term 'gender' refers to the socially expected/perceived dimensions of behaviour associated with males and females - masculinity and femininity.

The Australian Bureau of Statistics advises that the correct terminology for this data element is sex.

Information collection for transsexuals and people with transgender issues should be treated in the same manner.

To avoid problems with edits, transsexuals undergoing a sex change operation should have their sex at time of hospital admission recorded.

Related metadata: is used in the derivation of Diagnosis related group vers 1 supersedes previous data element Sex vers 2

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Demographic characteristic

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

Comments:

This item enables standardisation of the collection of information relating to sex (to include indeterminate), gender, people with transgender issues and transsexuals.

In collection systems (ie on forms and computer screens) Male and Female may be mapped to M and F respectively for collection purposes; however, they should be stored within information systems as the codes 1 and 2 respectively.

DSS - Diabetes (clinical):

Referring to the National Diabetes Register Statistical profile (December 2000), the sex ratio varied with age. For ages less than 25 years, numbers of males and females were similar. At ages 25-44 years, females strongly outnumbered males, reflecting the effect of gestational diabetes in women from this group. For older age groups (45-74 years), males strongly outnumber females and in the group of 75 and over, the ratio of males to females was reversed, with a substantially lower proportion of males in the population in this age group due to the higher female life expectancy. (AIHW National Mortality Database 1997/98; National Diabetes Register; Statistical Profile, December 2000)

Source of referral to alcohol and other drug treatment service

Identifying and Definitional Attributes

Knowledgebase ID:	000444	Version No: 2
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/03	
Definition:	The source from which the person was transferred or referred to the alcohol and other drug treatment service.	
Context:	Alcohol and other drug treatment services: Source of referral is important in assisting in the analyses of inter-sectoral patient/client flow and for health care planning.	

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	NN
Minimum size:	2
Maximum size:	2
Data domain:	<ul style="list-style-type: none"> 10 Non-agency individual 11 Self 12 Family member/friend 13 General practitioner 18 Other individual 20 Agency 21 Hospital 22 Community mental health care service 23 Alcohol and other drug treatment service 24 Other community/health care service 25 Community-based correctional service 26 Police diversion 27 Court diversion 28 Other agency 99 Not stated/inadequately described

Guide for use:	Code 10	Non-agency/individual refers to a person such as a friend or a general practitioner.
	Code 13	General practitioner includes vocationally registered general practitioners, vocationally registered general practitioner trainees and other primary-care medical practitioners in private practice.
	Code 20	Agency refers to an organisation such as a hospital or a health care service.

- Code 21 Includes public and private hospitals, hospitals specialising in dental, ophthalmic aids and other specialised medical or surgical care, satellite units managed and staffed by a hospital, emergency departments of hospitals, and mothercraft hospitals.
- Code 22–23 Includes both residential and non-residential services.
- Code 24 Includes outpatient clinics.

Verification rules:**Collection methods:**

Related metadata: supersedes previous data element Source of referral to alcohol and other drug treatment service vers 1

Administrative Attributes**Source document:****Source organisation:****Information model link:**

NHIM Request for/entry into service event

Data Set Specifications:

NMDS - Alcohol and other drug treatment services

Start date**End date**

01/07/2003

Comments:

Source of referral to public psychiatric hospital

Identifying and Definitional Attributes

Knowledgebase ID:	000150	Version No:	3
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/97		
Definition:	Source from which the person was transferred/referred to the public psychiatric hospital.		
Context:	To assist in analyses of intersectoral patient flow and health care planning.		

Relational and Representational Attributes

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

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

Guide for use:

Verification rules:

Collection methods:

Related metadata: supplements the data element Mode of separation vers 3
supersedes previous data element Source of referral vers 1

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Request for/entry into service event

Data Set Specifications:	Start date	End date
NMDS - Admitted patient care	01/07/1997	
NMDS - Admitted patient mental health care	01/07/2000	

Comments:

Specialised service indicators

Identifying and Definitional Attributes

Knowledgebase ID:	000321	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/89	
Definition:	Specialised services provided in establishments.	
Context:	Health services: Essential to provide a broad picture of the availability of these key specialised services by State and region and to assist with planning if services are over supplied in one region relative to another.	

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	AN.NN
Minimum size:	1
Maximum size:	5

Data domain:	1	Yes
	2	No

Guide for use:	Each of the following specialised services should be coded separately.
	E4.1 Obstetric/maternity service: A specialised facility dedicated to the care of obstetric/maternity patients.
	E4.2 Specialist paediatric service: A specialised facility dedicated to the care of children aged 14 or less.
	E4.3 Psychiatric unit/ward: A specialised unit/ward dedicated to the treatment and care of admitted patients with psychiatric, mental, or behavioural disorders.
	E4.4. Intensive care unit (level III): A specialised facility dedicated to the care of paediatric and adult patients requiring intensive care and sophisticated technological support services.
	E4.5 Hospice care unit: A facility dedicated to the provision of palliative care to terminally ill patients.
	E4.6 Nursing home care unit: A facility dedicated to the provision of nursing home care.
	E4.7 Geriatric assessment unit: Facilities dedicated to the Commonwealth-approved assessment of the level of dependency of (usually) aged individuals either for purposes of initial admission to a long-stay institution or for purposes of reassessment of dependency levels of existing long-stay institution residents.
	E4.8 Domiciliary care service: A facility/service dedicated to the provision of nursing or other professional paramedical care or treatment and non-qualified domestic assistance to patients in their own homes or in residential institutions not part of the establishment.
	E4.9 Alcohol and drug unit: A facility/service dedicated to the treatment of alcohol and drug dependence.

E4.10 Acute spinal cord injury unit (SS):

A specialised facility dedicated to the initial treatment and subsequent ongoing management and rehabilitation of patients with acute spinal cord injury, largely conforming to Australian Health Minister's Advisory Council guidelines for service provision.

E4.11 Coronary care unit:

A specialised facility dedicated to acute care services for patients with cardiac diseases.

E4.12 Cardiac surgery unit (SS):

A specialised facility dedicated to operative and peri-operative care of patients with cardiac disease.

E4.13 Acute renal dialysis unit (SS):

A specialised facility dedicated to dialysis of renal failure patients requiring acute care.

E4.14 Maintenance renal dialysis centre (SS):

A specialised facility dedicated to maintenance dialysis of renal failure patients. It may be a separate facility (possibly located on hospital grounds) or known as a satellite centre or a hospital-based facility but is not a facility solely providing training services.

E4.15 Burns unit (level III) (SS):

A specialised facility dedicated to the initial treatment and subsequent rehabilitation of the severely injured burns patient (usually >10 per cent of patients body surface affected).

E4.16 Major plastic/reconstructive surgery unit (SS):

A specialised facility dedicated to general purpose plastic and specialised reconstructive surgery, including maxillofacial, microsurgery and hand surgery.

E4.17 Oncology (cancer treatment) unit (SS):

A specialised facility dedicated to multidisciplinary investigation, management, rehabilitation and support services for cancer patients. Treatment services include surgery, chemotherapy and radiation.

E4.18 Neonatal intensive care unit (level III) (SS):

A specialised facility dedicated to the care of neonates requiring care and sophisticated technological support. Patients usually require intensive cardiorespiratory monitoring, sustained assistance ventilation, long-term oxygen administration and parenteral nutrition.

E4.19 In-vitro fertilisation unit:

A specialised facility dedicated to the investigation of infertility provision of in-vitro fertilisation services.

E4.20 Comprehensive epilepsy centre (SS):

A specialised facility dedicated to seizure characterisation, evaluation of therapeutic regimes, pre-surgical evaluation and epilepsy surgery for patients with refractory epilepsy.

E4.21 Transplantation unit:

A specialised facility dedicated to organ retrieval, transplantation and ongoing care of the transplant recipient.

- bone marrow
- renal
- heart, including heart-lung
- liver
- pancreas.

E4.22 Clinical genetics unit (SS):

A specialised facility dedicated to diagnostic and counselling services for clients who are affected by, at risk of or anxious about genetic disorders.

E4.23 Sleep centre:

A specialised facility linked to a sleep laboratory dedicated to the investigation and management of sleep disorders.

E4.24 Neuro surgical unit:

A specialised facility dedicated to the surgical treatment of neurological conditions.

E4.25 Infectious diseases unit:

A specialised facility dedicated to the treatment of infectious diseases.

E4.26 AIDS unit:

A specialised facility dedicated to the treatment of AIDS patients.

E4.27 Diabetes unit:

A specialised facility dedicated to the treatment of diabetics.

E4.28 Rehabilitation unit:

Dedicated units within recognised hospitals which provide post-acute rehabilitation and are designed as such by the State health authorities (see data element Care type).

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 Organisation characteristic

Data Set Specifications:

NMDS - Public hospital establishments

Start date

End date

01/07/1989

Comments:

State/Territory identifier

Identifying and Definitional Attributes

Knowledgebase ID:	000380	Version No: 3
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/03	
Definition:	An identifier for Australian State or Territory.	
Context:	Public health care.	

Relational and Representational Attributes

Datatype:	Numeric																		
Representational form:	Code																		
Representational layout:	N																		
Minimum size:	1																		
Maximum size:	1																		
Data domain:	<table> <tr><td>1</td><td>New South Wales</td></tr> <tr><td>2</td><td>Victoria</td></tr> <tr><td>3</td><td>Queensland</td></tr> <tr><td>4</td><td>South Australia</td></tr> <tr><td>5</td><td>Western Australia</td></tr> <tr><td>6</td><td>Tasmania</td></tr> <tr><td>7</td><td>Northern Territory</td></tr> <tr><td>8</td><td>Australian Capital Territory</td></tr> <tr><td>9</td><td>Other territories (Cocos (Keeling) Islands, Christmas Island and Jervis Bay Territory)</td></tr> </table>	1	New South Wales	2	Victoria	3	Queensland	4	South Australia	5	Western Australia	6	Tasmania	7	Northern Territory	8	Australian Capital Territory	9	Other territories (Cocos (Keeling) Islands, Christmas Island and Jervis Bay Territory)
1	New South Wales																		
2	Victoria																		
3	Queensland																		
4	South Australia																		
5	Western Australia																		
6	Tasmania																		
7	Northern Territory																		
8	Australian Capital Territory																		
9	Other territories (Cocos (Keeling) Islands, Christmas Island and Jervis Bay Territory)																		

Guide for use:	DSS - Health care client identification: When used specifically in the collection of address information for a health care client, the following local implementation rules may be applied: <ul style="list-style-type: none"> - NULL may be used to signify an unknown address State - Code 0 may be used to signify an overseas address.
-----------------------	---

Verification rules:

Collection methods:

Related metadata:	relates to the data element Address type vers 1
	relates to the data element Australian postcode vers 1
	relates to the data element Postal delivery point identifier vers 1
	is a composite part of Establishment identifier vers 4
	supersedes previous data element State identifier vers 2
	relates to the data element Suburb/town/locality vers 1

Administrative Attributes

Source document: Adapted from Australian Standard Geographic Classification, Australian Bureau of Statistics, Catalogue No. 1216.0

Source organisation: National Health Data Committee

Information model link:

NHIM Address element

Data Set Specifications:

DSS - Health care client identification

Start date

End date

01/01/2003

Comments:

State/Territory of birth

Identifying and Definitional Attributes

Knowledgebase ID:	000155	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/96		
Definition:	The State/Territory in which the birth occurred.		
Context:	NMDS - Perinatal:		
	To enable analyses by State/Territory of delivery.		

Relational and Representational Attributes

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

Data domain:	1	New South Wales
	2	Victoria
	3	Queensland
	4	South Australia
	5	Western Australia
	6	Tasmania
	7	Northern Territory
	8	Australian Capital Territory
	9	Other territories (Cocos (Keeling) Islands, Christmas Island and Jervis Bay Territory)

Guide for use:

Verification rules:

Collection methods:

Related metadata:

Administrative Attributes

Source document:

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Other setting

Data Set Specifications:	Start date	End date
NMDS - Perinatal	01/07/1997	
DSS - Health care client identification	01/01/2003	

Comments:

Status of the baby

Identifying and Definitional Attributes

Knowledgebase ID: 000159 **Version No:** 1

Metadata type: Data Element

Admin. status: Current
01/07/96

Definition: Status of the baby at birth.

Context: Perinatal statistics:
Essential to analyse outcome of pregnancy.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Live birth
2	Stillbirth (foetal death)
9	Not stated

Guide for use: Live birth is the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered liveborn (World Health Organization (WHO) 1992 definition).

Stillbirth is a foetal death prior to the complete expulsion or extraction from its mother of a product of conception of 20 or more completed weeks of gestation or of 400 g or more birthweight; the death is indicated by the fact that after such separation the foetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. (This is the same as the WHO definition of foetal death, except that there are no limits of gestational age or birthweight for the WHO definition.)

Verification rules:

Collection methods:

Related metadata:

- is qualified by Apgar score at 1 minute vers 1
- relates to the data element concept Live birth vers 1
- is used in conjunction with Resuscitation of baby vers 2
- relates to the data element concept Stillbirth (foetal death) vers 1

Administrative Attributes

Source document:

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Physical wellbeing

Data Set Specifications:

NMDS - Perinatal

Start date

End date

01/07/1997

Comments:

Stillbirth (foetal death)

Identifying and Definitional Attributes

Knowledgebase ID:	000160	Version No: 1
Metadata type:	Data Element Concept	
Admin. status:	Current	
	01/07/96	
Definition:	<p>A foetal death prior to the complete expulsion or extraction from its mother of a product of conception of 20 or more completed weeks of gestation or of 400 g or more birthweight.</p> <p>The death is indicated by the fact that after such separation the foetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.</p>	
Context:	Perinatal.	

Relational and Representational Attributes

Datatype:	
Representational form:	
Representational layout:	
Minimum size:	
Maximum size:	
Data domain:	
Guide for use:	
Verification rules:	
Collection methods:	
Related metadata:	

Administrative Attributes

Source document:		
Source organisation:	National Perinatal Data Development Committee	
Information model link:		
	NHIM Death event	
Data Set Specifications:	Start date	End date

Comments:	<p>The World health Organization definition of live birth, and the legal definition used in Australian States and Territories, do not specify any lower limit for gestational age or birthweight. In practice, liveborn foetuses of less than 20 weeks' gestation are infrequently registered as live births. In analysing data from the perinatal collections, it is recommended that the same criteria of gestational age and birthweight should be used for live births and stillbirths. Births for which gestational age and birthweight have not been recorded (usually occurring outside hospitals) should be included in the perinatal collections if it seems likely that the criteria have been met.</p> <p>Terminations of pregnancy performed at gestational ages of 20 or more weeks should be included in perinatal collections and should be recorded either as stillbirths or, in the unlikely event of showing evidence of life, as live births.</p>
------------------	--

Suburb/town/locality

Identifying and Definitional Attributes

Knowledgebase ID:	000787	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/01/03	
Definition:	The full name of the general locality containing the specific address.	
Context:		

Relational and Representational Attributes

Datatype:	Alphabetic
Representational form:	Text
Representational layout:	A(46)
Minimum size:	1
Maximum size:	46

Data domain: Valid name as per the Australian Postcode File

Guide for use:

Verification rules: This data should be verified against the Australia Post Postcode File (see www.auspost.com.au/postcodes). Alternatively, contact State or Territory Health Authorities for Postcode files.

Collection methods: Unknown person address:
Enter 'Unknown' in the Suburb/town/locality field.
No fixed address
Enter 'Unknown' in the Suburb/town/locality field.

Related metadata: relates to the data element Address type vers 1
relates to the data element Australian postcode vers 1
is used in the derivation of Postal delivery point identifier vers 1
relates to the data element State/Territory identifier vers 3

Administrative Attributes

Source document: AS5017 Health care client identification

Source organisation: Standards Australia

Information model link:

NHIM Address element

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

Comments:

Superannuation employer contributions (including funding basis)

Identifying and Definitional Attributes

Knowledgebase ID: 000237 **Version No:** 1

Metadata type: Data Element

Admin. status: Current
01/07/89

Definition: Contributions paid or (for an emerging cost scheme) that should be paid (as determined by an actuary) on behalf of establishment employees either by the establishment or a central administration such as a State health authority, to a superannuation fund providing retirement and related benefits to establishment employees.

The following different funding bases are identified:

- paid by hospital to fully funded scheme
- paid by Commonwealth Government or State government to fully funded scheme
- unfunded or emerging costs schemes where employer component is not presently funded.

Fully funded schemes are those in which employer and employee contributions are paid into an invested fund. Benefits are paid from the fund. Most private sector schemes are fully funded.

Emerging cost schemes are those in which the cost of benefits is met at the time a benefit becomes payable, i.e. there is no ongoing invested fund from which benefits are paid. The Commonwealth superannuation fund is an example of this type of scheme as employee benefits are paid out of general revenue.

Context: Health expenditure:

Superannuation employer contributions are a significant element of establishment expenditure and, as such, are required for health expenditure analysis at the national level. The funding basis is required for cost comparison purposes particularly in the case of unfunded or emerging cost schemes where no actual contribution is being presently made but ultimately employer liability will have to be funded.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Currency

Representational layout: \$999,999,999

Minimum size: 2

Maximum size: 12

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

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

Verification rules:

Collection methods:

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

Administrative Attributes

Source document:

Source organisation: National minimum data set working parties

Information model link:

NHIM Recurrent expenditure

Data Set Specifications:

NMDS - Public hospital establishments

Start date

End date

01/07/1989

Comments:

The definition specifically excludes employee superannuation contributions (not a cost to the establishment) and superannuation final benefit payments. In private enterprise some superannuation schemes are partially funded but this is considered too complex a distinction for national minimum data sets. It is noted that the emergence of salary sacrifice schemes allows employees to forego salary for higher superannuation contributions. If these become significant, national minimum data sets may have to take them into account at a future stage.

Surgical specialty

Identifying and Definitional Attributes

Knowledgebase ID:	000161	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/01/95	
Definition:	The area of clinical expertise held by the doctor who will perform the elective surgery.	
Context:	<p>Elective surgery:</p> <p>Many hospitals manage their waiting lists on a specialty basis. Current data show that the total ready-for-care times waited and numbers of long-wait patients vary significantly between specialties. Furthermore, the hospital capacity to handle the demand for elective surgery varies with specialty.</p>	

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	NN
Minimum size:	2
Maximum size:	2
Data domain:	<ul style="list-style-type: none"> 01 Cardio-thoracic surgery 02 Ear, nose and throat surgery 03 General surgery 04 Gynaecology 05 Neurosurgery 06 Ophthalmology 07 Orthopaedic surgery 08 Plastic surgery 09 Urology 10 Vascular surgery 11 Other

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
Waiting Times Working Group

Information model link:

NHIM Labour characteristic

Data Set Specifications:

NMDS - Elective surgery waiting times

Start date**End date**

01/01/1995

Comments:

The above classifications are consistent with the Recommended Medical Specialties and Qualifications agreed by the National Specialist Qualification Advisory Committee of Australia, September 1993. Vascular surgery is a subspecialty of general surgery. The Royal Australian College of Surgeons has a training program for vascular surgeons. The specialties listed above refer to the surgical component of these specialties - ear, nose and throat surgery refers to the surgical component of the specialty otolaryngology; gynaecology refers to the gynaecological surgical component of obstetrics and gynaecology; ophthalmology refers to the surgical component of the specialty (patients awaiting argon laser phototherapy are not included).

Teaching status

Identifying and Definitional Attributes

Knowledgebase ID: 000322 **Version No:** 1

Metadata type: Data Element

Admin. status: Current
01/07/89

Definition: An indicator (yes/no) to identify the non-direct patient care activity of teaching for a particular establishment. This is where teaching (associated with a university) is a major program activity of the establishment. It is primarily intended to relate to teaching hospitals affiliated with universities providing undergraduate medical education as advised by the relevant State health authority.

Context: Health services:
The non-direct care activity of teaching can involve the consumption of considerable resources. In comparisons of cost in relation to establishment output, it is important to be aware of particular establishments which are devoting substantial resources to activities not relating to output as measured in terms of either inpatient bed days or outpatient occasions of service. Teaching can be one of the variables in any regression analysis undertaken. In this context, teaching relates to teaching hospitals affiliated with universities providing undergraduate medical education as advised by the relevant State health authority.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Yes
2	No
9	Unknown

Guide for use:

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 Organisation characteristic

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

Comments:

The initial intention based on the Taskforce on National Hospital Statistics approach had been to have non-direct care activity indicators for all of the following non-direct patient care activities:

- teaching
- research
- group or community contacts
- public health activities
- mobile centre and/or part-time service.

However, the Resources Working Party decided to delete 2, 3, 4 and 5 and place the emphasis on teaching where teaching (associated with a university) was a major program activity of the hospital. The working party took the view that it was extremely difficult to identify research activities in health institutions because many staff consider that they do research as part of their usual duties. The research indicator was thus deleted and the teaching indicator was agreed to relate to teaching hospitals affiliated with universities providing undergraduate medical education, as advised by the relevant State health authority. If a teaching hospital is identified by a Yes/no indicator then it is not necessary to worry about research (based on the assumption that if you have teaching, you have research).

Telephone number

Identifying and Definitional Attributes

Knowledgebase ID:	000791	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/01/03	
Definition:	Person or organisation contact telephone number.	

Context:

Relational and Representational Attributes

Datatype:	Alphanumeric
Representational form:	Text
Representational layout:	N(40)
Minimum size:	0
Maximum size:	40

Data domain: Numbers and spaces only.

Guide for use: More than one phone number may be recorded as required. Each phone number should have an appropriate Telephone number type code assigned. Record the full phone number (including any prefixes) with no punctuation (hyphens or brackets).

Verification rules: Numbers and spaces only.

Collection methods: Prefix plus telephone number:
Record the prefix plus telephone number. The default should be the local prefix with an ability to overtype with a different prefix.
For example, 08 8226 6000 or 0417 123456.
Punctuation:
Do not record punctuation.
For example, (08) 8226 6000 or 08-8226 6000 would not be correct.
Unknown:
Leave the field blank.

Related metadata: is qualified by Telephone number type vers 1

Administrative Attributes

Source document: AS5017 Health care client identification

Source organisation: Standards Australia

Information model link:

NHIM Address element

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

Comments:

Telephone number type

Identifying and Definitional Attributes

Knowledgebase ID: 000792 **Version No:** 1

Metadata type: Data Element

Admin. status: Current
01/01/03

Definition: A code representing a type of telephone number.

Context: Primarily concerned with the clinical use of Health care client identification data. For use by health and health-related establishments that create, use or maintain records on health care clients. Establishments should use this Standard, where appropriate, for collecting data when registering health care clients or potential health care clients. The positive and unique identification of health care clients is a critical event in health service delivery, with direct implications for the safety and quality of health care.

Relational and Representational Attributes

Datatype: Alphabetic

Representational form: Code

Representational layout: A

Minimum size: 0

Maximum size: 1

Data domain:

B	Business or work
H	Home
M	Personal mobile
N	Contact number (not own)
O	Business or work mobile
T	Temporary

Guide for use: Where more than one telephone number has been recorded, then each telephone number should have the appropriate Telephone number type code assigned.

Verification rules:

Collection methods:

Related metadata: is a qualifier of Telephone number vers 1

Administrative Attributes

Source document: AS5017 Health care client identification

Source organisation: Standards Australia

Information model link:

NHIM Address element

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

Comments:

Time of commencement of service event

Identifying and Definitional Attributes

Knowledgebase ID:	000357	Version No: 2
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/01	
Definition:	The time at which the delivery of a service commences. The service is defined as commencing when a health care professional first takes responsibility for the patient/client's care.	
Context:	Community health care. Hospital non-admitted patient care.	

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Time
Representational layout:	HHMM
Minimum size:	4
Maximum size:	4
Data domain:	Valid time in 24-hour clock format.
Guide for use:	24-hour clock format.
Verification rules:	
Collection methods:	
Related metadata:	<ul style="list-style-type: none"> relates to the data element Date of commencement of service event vers 2 relates to the data element Date of triage vers 1 relates to the data element Date patient presents vers 2 relates to the data element Emergency department waiting time to admission vers 1 relates to the data element Emergency department waiting time to service delivery vers 2 relates to the data element concept Patient presentation at emergency department vers 1 supersedes previous data element Time of service event vers 1 relates to the data element Time of triage vers 1 relates to the data element Time patient presents vers 1

Administrative Attributes

Source document:	
Source organisation:	National Institution Based Ambulatory Model Reference Group National Health Data Committee
Information model link:	NHIM Service provision event

Data Set Specifications:

NMDS - Emergency department waiting times

Start date

01/07/2001

End date

Comments:

Time of triage

Identifying and Definitional Attributes

Knowledgebase ID:	000354	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/98	
Definition:	The time at which the patient is triaged.	
Context:	Admitted patient care:	
	Required to identify the commencement of the service and calculation of waiting times.	

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Time
Representational layout:	HHMM
Minimum size:	4
Maximum size:	4
Data domain:	Valid time in 24-hour clock format.
Guide for use:	24-hour clock format.
Verification rules:	
Collection methods:	
Related metadata:	<ul style="list-style-type: none"> relates to the data element Admission date vers 4 relates to the data element Admission time vers 2 relates to the data element Date of service event vers 1 relates to the data element Date of triage vers 1 relates to the data element Date patient presents vers 2 relates to the data element Emergency department waiting time to admission vers 1 relates to the data element Emergency department waiting time to service delivery vers 2 relates to the data element concept Patient presentation at emergency department vers 1 relates to the data element Time of commencement of service event vers 2 relates to the data element Time patient presents vers 2 relates to the data element Triage category vers 1 relates to the data element Type of visit to emergency department vers 2

Administrative Attributes

Source document:

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

Information model link:

NHIM Assessment event

Data Set Specifications:

NMDS - Emergency department waiting times

Start date

End date

01/07/1999

Comments:

This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the NMDS - Emergency department waiting times.

Time patient presents

Identifying and Definitional Attributes

Knowledgebase ID:	000351	Version No: 2
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/01	
Definition:	The time at which the patient presents for the delivery of a service.	
Context:	Admitted patient care.	
	Community health care.	
	Hospital non-admitted patient care:	
	Required to identify commencement of a visit and for calculation of waiting times.	

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Time
Representational layout:	HHMM
Minimum size:	4
Maximum size:	4

Data domain: Time in 24-hour clock format.

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

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

The time that the patient presents is not necessarily:

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

Verification rules:

Collection methods:

Related metadata:

- relates to the data element Admission time vers 2
- relates to the data element Date of triage vers 1
- relates to the data element Date patient presents vers 2
- relates to the data element Emergency department waiting time to admission vers 1
- relates to the data element Emergency department waiting time to service delivery vers 2

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

relates to the data element Time of triage vers 1

supersedes previous data element Time patient presents vers 1

relates to the data element Triage category vers 1

Administrative Attributes

Source document:

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

Information model link:

NHIM Request for/entry into service event

Data Set Specifications:

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

Comments:

This data element is required to identify commencement of a visit and for calculation of waiting times. It supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the NMDS - Emergency department waiting times.

Tobacco smoking – consumption/quantity (cigarettes)

Identifying and Definitional Attributes

Knowledgebase ID:	000403	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/99	
Definition:	The number of cigarettes (manufactured or roll-your-own) smoked per day by a person.	

Context: Public health and health care: The number of cigarettes smoked is an important measure of the magnitude of the tobacco problem for an individual. Research shows that of Australians who smoke, the overwhelming majority smoke cigarettes (manufactured or roll-your-own) rather than other tobacco products. From a public health point of view, consumption level is relevant only for regular smokers (those who smoke daily or at least weekly).

Data on quantity smoked can be used to:

- evaluate health promotion and disease prevention programs (assessment of interventions)
- monitor health risk factors and progress towards National Health Goals and Targets
- ascertain determinants and consequences of smoking
- assess a person's exposure to tobacco smoke.

Relational and Representational Attributes

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

Data domain: Count of the number of cigarettes smoked daily.
99 Not stated/inadequately described

Guide for use: This data element is relevant only for persons who currently smoke cigarettes daily or at least weekly. Daily consumption should be reported, rather than weekly consumption. Weekly consumption is converted to daily consumption by dividing by 7 and rounding to the nearest whole number.
Quantities greater than 98 (extremely rare) should be coded 98.

Verification rules:

Collection methods: The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults – interviewer administered (Questions 3a and 3b) and self-administered (Questions 2a and 2b) versions. The questions cover persons aged 18 years and over.

Related metadata: is qualified by Date of birth vers 4
is qualified by Tobacco smoking – frequency vers 1
is qualified by Tobacco smoking – product vers 1

Administrative Attributes

Source document: Standard Questions on the Use of Tobacco Among Adults (1998)

Source organisation: Australian Institute of Health and Welfare

Information model link:

NHIM Lifestyle characteristic

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

Comments: Where this information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

The Standard Questions on the Use of Tobacco Among Adults (self- and interviewer-administered versions) can be obtained from the National Centre for Monitoring Cardiovascular Disease at the AIHW, telephone (02) 6244 1000.

Tobacco smoking – duration (daily smoking)

Identifying and Definitional Attributes

Knowledgebase ID:	000404	Version No: 1
Metadata type:	Derived Data Element	
Admin. status:	Current	
	01/07/99	
Definition:	Duration (in years) of daily smoking for a person who is now a daily smoker or has been a daily smoker in the past.	

Context:	Public health and health care: Duration of daily smoking is an indicator of exposure to increased risk to health. In this data element, duration is measured as the years elapsed from the time the person first started smoking daily and when they most recently quit smoking daily (or the present for those persons who still smoke daily). There may have been intervening periods when the person did not smoke daily. However, as the negative health effects of smoking accumulate over time, the information on duration of daily smoking, as measured in this data element, remains useful, despite any intervening periods of non-daily smoking.
-----------------	--

Relational and Representational Attributes

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

Data domain:	Number of completed years or 99 Not stated/inadequately described
---------------------	--

Guide for use:	In order to estimate duration of smoking the person's date of birth or current age should also be collected. If a person reports that they smoke daily now then duration is the difference between the start-age and the person's current age. If a person reports that they smoked daily in the past but do not smoke daily now then duration is the difference between the quit age and the start age. Record duration of less than one year as 0.
-----------------------	--

Verification rules:

Collection methods:	The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults – interviewer administered (Question 1, 5, 6, 7) and self-administered (Question 1, 3, 3a, 4) versions. The questions cover persons aged 18 years of age and over.
----------------------------	--

Related metadata:	is qualified by Date of birth vers 4 is qualified by Tobacco smoking – ever daily use vers 1 is derived from Tobacco smoking – quit age (daily smoking) vers 1 is derived from Tobacco smoking – start age (daily smoking) vers 1
--------------------------	--

Administrative Attributes

Source document: Standard Questions on the Use of Tobacco Among Adults (1998)

Source organisation: Australian Institute of Health and Welfare

Information model link:

NHIM Lifestyle characteristic

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

Comments: Where this information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables. It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

The Standard Questions on the Use of Tobacco Among Adults Available etc. are available from the National Centre for Monitoring Cardiovascular Disease at the AIHW, telephone (02) 6244 1000.

Tobacco smoking – ever daily use

Identifying and Definitional Attributes

Knowledgebase ID:	000405	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/99	
Definition:	Whether a person has ever smoked tobacco in any form daily in his or her lifetime.	

Context:	Public health and health care. Whether a person has ever smoked on a daily basis can be used to assess an individual's health risk from smoking and to monitor population trends in smoking behaviour.
	It can also be used to: <ul style="list-style-type: none"> - evaluate health promotion and disease prevention programs (assessment of interventions) - monitor health risk factors - ascertain determinants and consequences of smoking.

Relational and Representational Attributes

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

Data domain:	1	Ever-daily
	2	Never-daily

Guide for use:	If a person reports that they now smoke cigarettes, cigars, pipes or any other tobacco products daily OR if they report that in the past they have been a daily smoker, they are coded to 1 (ever-daily)
	If a person reports that they have never smoked cigarettes, cigars, pipes or any other tobacco products daily AND they have never in the past been a daily smoker then they are coded to 2 (never-daily)

Verification rules:

Collection methods:	The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults – interviewer administered (Question 1 and 5) and self-administered (Question 1 and 3) versions. The questions cover persons aged 18 years and over.
----------------------------	--

Related metadata:	is qualified by Date of birth vers 4
	is qualified by Tobacco smoking – frequency vers 1

Administrative Attributes

Source document: Standard Questions on the Use of Tobacco Among Adults (1998)

Source organisation: Australian Institute of Health and Welfare

Information model link:

NHIM Lifestyle characteristic

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

Comments:

Where the information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

The Standard Questions on the Use of Tobacco Among Adults Available etc. are available from the National Centre for Monitoring Cardiovascular Disease at the AIHW, telephone (02) 6244 1000.

Tobacco smoking – frequency

Identifying and Definitional Attributes

Knowledgebase ID: 000406 **Version No:** 1

Metadata type: Data Element

Admin. status: Current
01/07/99

Definition: How often a person now smokes a tobacco product.

Context: Public health and health care: The frequency of smoking helps to assess a person's exposure to tobacco smoke which is a known risk factor for cardiovascular disease and cancer. From a public health point of view, the level of consumption of tobacco as measured by frequency of smoking tobacco products is only relevant for regular smokers (persons who smoke daily or at least weekly).

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Smokes daily
2	Smokes at least weekly, but not daily
3	Smokes less often than weekly
4	Does not smoke at all

Guide for use: To record multiple use data, repeat the data field as many times as necessary, viz: product1, product2 etc. In most instances, data on both product and frequency are needed. In such situations, repeat both fields as many times as necessary, viz: product1, frequency1, product2, frequency2 etc.

Verification rules:

Collection methods: The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults – interviewer administered (Question 1) and self-administered (Question 1) versions. The questions relate to smoking of manufactured cigarettes, roll-your-own cigarettes, cigars, pipes and other tobacco products and are designed to cover persons aged 18 years and over.

Related metadata:

- is qualified by Date of birth vers 4
- is a qualifier of Tobacco smoking – consumption/quantity (cigarettes) vers 1
- relates to the data element Tobacco smoking – duration (daily smoking) vers 1
- relates to the data element Tobacco smoking – ever daily use vers 1
- is used in conjunction with Tobacco smoking – product vers 1
- relates to the data element Tobacco smoking – start age (daily smoking) vers 1

Administrative Attributes

Source document: Standard Questions on the Use of Tobacco Among Adults (1998)

Source organisation: Australian Institute of Health and Welfare

Information model link:

NHIM Lifestyle characteristic

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

Comments:

Where this information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

The Standard Questions on the Use of Tobacco Among Adults Available etc. are available from the National Centre for Monitoring Cardiovascular Disease at the AIHW, telephone (02) 6244 1000.

Tobacco smoking – product

Identifying and Definitional Attributes

Knowledgebase ID: 000407 **Version No:** 1

Metadata type: Data Element

Admin. status: Current
01/07/99

Definition: The type of tobacco product smoked by a person.

Context: Public health and health care:
Tobacco smoking is a known risk factor for cardiovascular disease and cancer. The type of tobacco product smoked by a person in conjunction with information about the frequency of smoking assists with establishing a profile of smoking behaviour at the individual or population level and with monitoring shifts from cigarette smoking to other types of tobacco products and vice versa.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Cigarettes - manufactured
2	Cigarettes - roll-your-own
3	Cigars
4	Pipes
5	Other tobacco product
6	None

Guide for use: To record multiple use data, repeat the data field as many times as necessary, viz: product1, product2 etc. In most instances, data on both product and frequency are needed. In such situations, repeat both fields as many times as necessary, viz: product1, frequency1; product2, frequency2 etc.

Verification rules:

Collection methods: The recommended standard for collecting information about smoking the above tobacco products is the Standard Questions on the Use of Tobacco Among Adults – interviewer or self-administered versions.

Related metadata: is qualified by Date of birth vers 4
is a qualifier of Tobacco smoking – consumption/quantity (cigarettes) vers 1
is used in conjunction with Tobacco smoking – frequency vers 1

Administrative Attributes

Source document: Standard Questions on the Use of Tobacco Among Adults (1998)

Source organisation: Australian Institute of Health and Welfare

Information model link:

NHIM Lifestyle characteristic

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

Comments:

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

The Standard Questions on the Use of Tobacco Among Adults Available etc. are available from the National Centre for Monitoring Cardiovascular Disease at the AIHW, telephone (02) 6244 1000.

Tobacco smoking – quit age (daily smoking)

Identifying and Definitional Attributes

Knowledgebase ID:	000408	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/99	
Definition:	Age (in years) at which a person who has smoked daily in the past and is no longer a daily smoker most recently stopped smoking daily.	
Context:	Public health and health care: Quit-age and start-age provide information on the duration of daily smoking and exposure to increased risk to health.	

Relational and Representational Attributes

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

Data domain: Age in completed years
99 Not stated/inadequately described

Guide for use: In order to estimate quit-age, the person's date of birth or current age should also be collected. Quit-age may be directly reported, or derived from the date the person quit smoking or the length of time since quitting, once the person's date of birth (or current age) is known.

Quit-age is relevant only to persons who have been daily smokers in the past and are not current daily smokers.

Verification rules:

Collection methods: The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults – interviewer administered (Question 6) and self-administered (Question 3a) versions. The questions cover persons aged 18 years and over.

The relevant question in each version of the questionnaires refers to when the person finally stopped smoking daily, whereas the definition for this data element refers to when the person most recently stopped smoking daily. However, in order to provide information on when the person most recently stopped smoking daily, the most appropriate question to ask at the time of collecting the information is when the person finally stopped smoking daily.

Related metadata: is qualified by Date of birth vers 4
is used in the derivation of Tobacco smoking – duration (daily smoking) vers 1
is used in conjunction with Tobacco smoking – start age (daily smoking) vers 1
is used in the derivation of Tobacco smoking – time since quitting (daily smoking) vers 1

is qualified by Tobacco smoking status vers 1

Administrative Attributes

Source document: Standard Questions on the Use of Tobacco Among Adults (1998)

Source organisation: Australian Institute of Health and Welfare

Information model link:

NHIM Lifestyle characteristic

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

Comments: Where the information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

The Standard Questions on the Use of Tobacco Among Adults Available etc. are available from the National Centre for Monitoring Cardiovascular Disease at the AIHW, telephone (02) 6244 1000.

Tobacco smoking – start age (daily smoking)

Identifying and Definitional Attributes

Knowledgebase ID:	000409	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/99	
Definition:	Age (in years) at which a person who has ever been a daily smoker first started to smoke daily.	
Context:	Public health and health care: Start-age may be used to derive duration of smoking, which is a much stronger predictor of the risks associated with smoking than is the total amount of tobacco smoked over time.	

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	NN
Minimum size:	2
Maximum size:	2
Data domain:	Age in completed years 99 Not stated/inadequately described
Guide for use:	This information is relevant only if a person currently smokes daily or has smoked daily in the past.
Verification rules:	
Collection methods:	The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults – interviewer administered (Question 7) and self-administered (Question 4) versions. The questions cover persons aged 18 years and over.
Related metadata:	is qualified by Date of birth vers 4 is used in the derivation of Tobacco smoking – duration (daily smoking) vers 1 is qualified by Tobacco smoking – ever daily use vers 1 is used in conjunction with Tobacco smoking – quit age (daily smoking) vers 1

Administrative Attributes

Source document:	Standard Questions on the Use of Tobacco Among Adults (1998)
Source organisation:	Australian Institute of Health and Welfare
Information model link:	NHIM Lifestyle characteristic

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

Where the information is collected by survey and the sample permits, population estimates should be presented by sex and age groups. The recommended age groups are: < 10, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20-24, 25-29 and 30. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

The Standard Questions on the Use of Tobacco Among Adults Available etc. are available from the National Centre for Monitoring Cardiovascular Disease at the AIHW, telephone (02) 6244 1000.

Tobacco smoking – time since quitting (daily smoking)

Identifying and Definitional Attributes

Knowledgebase ID:	000411	Version No: 1
Metadata type:	Derived Data Element	
Admin. status:	Current	
	01/07/99	
Definition:	Time since a person most recently quit daily smoking.	
Context:	Public health and health care:	
	Time since quitting daily smoking may give an indication of improvement in the health risk profile of a person. It is also useful in evaluating health promotion campaigns.	

Relational and Representational Attributes

Datatype:	Numeric	
Representational form:	Code	
Representational layout:	NN	
Minimum size:	2	
Maximum size:	2	
Data domain:	01	12 months (1 year)
	02	2 years etc. to 78
	79	79+ years
	80	Less than 1 month
	81	1 month
	82	2 months
	83	3 months
	84	4 months
	85	5 months
	86	6 months
	87	7 months
	88	8 months
	89	9 months
	90	10 months
	91	11 months
	92	months, not specified
	93	years, not specified
	99	not stated

Guide for use: In order to estimate time since quitting for all respondents, the person's date of birth or current age should also be collected.

For optimal flexibility of use, the time since quitting is coded as months or years. However, people may report the time that they quit smoking in various ways (e.g. age, a date, or a number of days or weeks ago). When the information is reported in weeks and is less than 4, or in days and is less than 28, then use code 80.

When the person reports the time since quitting as weeks ago, convert into months by dividing by 4 (rounded down to the nearest month).

If days reported are between 28 and 59, then use code 81.

Where the information is about age only, time since quitting (daily use) is the difference between quit-age and age at survey.

Verification rules:

Collection methods: The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults - interviewer administered (Question 6) and self-administered (Question 3) versions.

Related metadata:
 is qualified by Date of birth vers 4
 is qualified by Tobacco smoking - ever daily use vers 1
 is derived from Tobacco smoking - quit age (daily smoking) vers 1

Administrative Attributes

Source document: Standard Questions on the Use of Tobacco Among Adults (1998)

Source organisation: Australian Institute of Health and Welfare

Information model link:

NHIM Lifestyle characteristic

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

Comments: Where this information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

The Standard Questions on the Use of Tobacco Among Adults Available etc. are available from the National Centre for Monitoring Cardiovascular Disease at the AIHW, telephone (02) 6244 1000.

Tobacco smoking status

Identifying and Definitional Attributes

Knowledgebase ID: 000410 **Version No:** 1

Metadata type: Data Element

Admin. status: Current
01/07/99

Definition: A person's current and past smoking behaviour.

Context: Public health, health care and clinical settings:

Smoker type is used to define sub-populations of adults (age 18 years and over) based on their smoking behaviour. Smoking has long been known as a health risk factor. Population studies indicate a relationship between smoking and increased mortality/morbidity. This data element can be used to estimate smoking prevalence.

Other uses are to:

- evaluate health promotion and disease prevention programs (assessment of interventions)
- monitor health risk factors and progress towards National Health Goals and Targets

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Daily smoker
2	Weekly smoker
3	Irregular smoker
4	Ex-smoker
5	Never smoked

Guide for use: The above grouping subdivides a population into five mutually exclusive categories.

- Daily smoker: A person who smokes daily
- Weekly smoker: A person who smokes at least weekly but not daily
- Irregular smoker: A person who smokes less than weekly
- Ex-smoker: A person who does not smoke at all now, but has smoked at least 100 cigarettes or a similar amount of other tobacco products in his/her lifetime.
- Never-smoker: A person who does not smoke now and has smoked fewer than 100 cigarettes or similar amount of other tobacco products in his/her lifetime.

Verification rules:

Collection methods: The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults – interviewer administered (Questions 1 and 4) and self-administered (Questions 1 and 1a) versions. The questionnaires are designed to cover persons aged 18.

Related metadata: is qualified by Date of birth vers 4
relates to the data element Behaviour-related risk factor intervention vers 1
relates to the data element Behaviour-related risk factor intervention – purpose vers 1

Administrative Attributes

Source document: Standard Questions on the Use of Tobacco Among Adults (1998)

Source organisation: Australian Institute of Health and Welfare

Information model link:

NHIM Lifestyle characteristic

Data Set Specifications:

DSS - Cardiovascular disease (clinical)

Start date

End date

01/01/2003

Comments:

There are two other ways of categorising this information:

- Regular and irregular smokers where a regular smoker includes someone who is a daily smoker or a weekly smoker. 'Regular' smokers is the preferred category to be reported in prevalence estimates.
- Daily and occasional smokers where an occasional smoker includes someone who is a weekly or irregular smoker. The category of 'occasional' smoker can be used when the aim of the study is to draw contrast between daily smokers and other smokers. Where this information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

The Standard Questions on the Use of Tobacco Among Adults Available etc. are available from the National Centre for Monitoring Cardiovascular Disease at the AIHW, telephone (02) 6244 1000.

Tobacco smoking status – diabetes mellitus

Identifying and Definitional Attributes

Knowledgebase ID:	000846	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/01/03	
Definition:	Whether an individual has been a regular smoker (daily or weekly) of any tobacco material over the previous 3 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	Yes, has smoked daily or weekly over the previous 3 months
	2	No, has not smoked daily or weekly over the previous 3 months
	9	Not stated/inadequately described

Guide for use: Record whether or not regular smoking (daily or weekly) of any tobacco material has occurred over the past 3 months. Record as no if the person has not smoked at all over the past 3 months or has been an irregular smoker (i.e. not daily or weekly).

Verification rules:

Collection methods: Ask the individual if he/she has regularly smoked (daily or weekly) any tobacco material over the past 3 months.

Related metadata:

- relates to the data element Tobacco smoking – consumption/quantity (cigarettes) vers 1
- relates to the data element Tobacco smoking – duration (daily smoking) vers 1
- relates to the data element Tobacco smoking – ever daily use vers 1
- relates to the data element Tobacco smoking – frequency vers 1
- relates to the data element Tobacco smoking – product vers 1
- relates to the data element Tobacco smoking – quit age (daily smoking) vers 1
- relates to the data element Tobacco smoking – start age (daily smoking) vers 1
- relates to the data element Tobacco smoking – time since quitting (daily smoking) vers 1
- relates to the data element Tobacco smoking status vers 1

Administrative Attributes

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

Source organisation: National Diabetes Data Working Group

Information model link:

NHIM Lifestyle characteristic

Data Set Specifications:

DSS - Diabetes (clinical)

Start date

End date

01/01/2003

Comments:

Smoking is the act of drawing into the mouth and puffing out the smoke of tobacco contained in a cigarette, cigar or pipe. Tobacco smoke contains a number of harmful substances including poisons, various irritant and carcinogenic compounds. For people with diabetes smoking is one of the most powerful treatable risk factors.

Associated with hypertension, diabetes and hypercholesterolemia, smoking is a definite health hazard for coronary heart disease.

Total contract patient days

Identifying and Definitional Attributes

Knowledgebase ID:	000429	Version No: 1
Metadata type:	Derived Data Element	
Admin. status:	Current	
	01/07/00	
Definition:	Sum of the number of contract patient days (Contracted care completion date minus Contracted care commencement date) for all periods within the hospital stay.	
Context:	Admitted patient care.	

Relational and Representational Attributes

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

Data domain: Calculated sum of contract patient days.

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

Contract patient days are included in the total count of patient days. If necessary, contract patient days can be distinguished from other patient days by using the following rules:

The day the contract commences is counted as a contract patient day.

If the patient is on contract from midnight to 2359 count as a contract patient day.

The day a contract is completed is not counted as a contract patient day.

If the patient is admitted and commences a contract on the same day, this is not counted as a contract patient day.

If a contract is completed and the patient is separated on the same day, the day should not be counted as a contract or other patient day.

Verification rules:

Collection methods:

Related metadata:

- relates to the data element Contract establishment identifier vers 1
- relates to the data element Contract procedure flag vers 1
- relates to the data element Contract role vers 1
- relates to the data element Contract type vers 1
- relates to the data element Contracted care commencement date vers 1
- relates to the data element Contracted care completion date vers 1
- relates to the data element Contracted hospital care vers 1
- relates to the data element Patient days vers 3

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Performance indicator

Data Set Specifications:

Start date

End date

Comments:

Total hours worked by a medical practitioner

Identifying and Definitional Attributes

Knowledgebase ID:	000394	Version No: 2
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/97	
Definition:	The total hours worked in a week in a job by a medical practitioner, including any on-call hours actually worked (includes patient care and administration).	

Context:	Health labour force:
	Used in relation to issues of economic activity, productivity, wage rates, working conditions etc. Used to develop capacity measures relating to total time available. Assists in analysis of human resource requirements and labour force modelling. Used to determine full-time and part-time work status and to compute full-time equivalents (FTE) (see entry for FTE). Often the definition for full-time or FTE differs (35, 37.5 and 40 hours) and knowing total hours and numbers of individuals allows for variances in FTE.

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	NNN
Minimum size:	3
Maximum size:	3
Data domain:	Total hours, expressed as 000, 001 etc. 999 Not stated/inadequately described
Guide for use:	Data element relates to each position (job) held by a medical practitioner, not the aggregate of hours worked in all.
Verification rules:	Value must be less than 169 (except for 999).
Collection methods:	There are inherent problems in asking for information on number of hours usually worked per week, for example, reaching a satisfactory definition and communicating this definition to the respondents in a self-administered survey. Whether hours worked are collected for main job only, or main job and one or more additional jobs, it is important that a total for all jobs is included.
Related metadata:	relates to the data element Hours on-call (not worked) by medical practitioner vers 2 supersedes previous data element Hours worked vers 1 relates to the data element Hours worked by medical practitioner in direct patient care vers 2

Administrative Attributes

Source document:

Source organisation: National Health Labour Force Data Working Group

Information model link:

NHIM Labour characteristic

Data Set Specifications:

NMDS - Health labour force

Start date

End date

01/07/1997

Comments:

It is often argued that health professionals contribute a considerable amount of time to voluntary professional work and that this component needs to be identified. This should be considered as an additional item, and kept segregated from data on paid hours worked.

Total leave days

Identifying and Definitional Attributes

Knowledgebase ID:	000163	Version No: 3
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/96	
Definition:	Sum of the length of leave (date returned from leave minus date went on leave) for all periods within the hospital stay.	

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

Relational and Representational Attributes

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

Data domain: Count in number of days.

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

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

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

Collection methods:

Related metadata: supersedes previous data element Total leave 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	
NMDS - Admitted patient mental health care	01/07/1997	

Comments:

It should be noted that for private patients in public and private hospitals, s.3 (12) of the *Health Insurance Act 1973* (Commonwealth) currently applies a different leave day count, Commonwealth Department of Human Services and Health HBF Circular 354 (31 March 1994). This item was modified in July 1996 to exclude the previous differentiation between the psychiatric and other patients.

Total psychiatric care days

Identifying and Definitional Attributes

Knowledgebase ID: 000164 **Version No:** 2

Metadata type: Derived Data Element

Admin. status: Current
01/07/98

Definition: The sum of the number of days or part days of stay that the person received care as an admitted patient or resident within a designated psychiatric unit, minus the sum of leave days occurring during the stay within the designated unit.

Context: Admitted patient and residential mental health care:
This data element is required to identify the characteristics of patients treated in specialist psychiatric units located within acute care hospitals or 24-hour staffed Community-based residential services and to analyse the activities of these units and services.
Community mental health care:
This data element is required to identify the characteristics of patients treated in specialist psychiatric 24-hour staffed Community-based residential services and to analyse the activities of these units. The data element is necessary to describe and evaluate the progress of mainstreaming of mental health services.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNNNN

Minimum size: 1

Maximum size: 5

Data domain:

Guide for use: Designated psychiatric units are staffed by health professionals with specialist mental health qualifications or training and have as their principal function the treatment and care of patients affected by mental disorder. The unit may or may not be recognised under relevant State and Territory legislation to treat patients on an involuntary basis. Patients are admitted patients in the acute and psychiatric hospitals and residents in Community-based residences.

Public acute care hospitals:
Designated psychiatric units in public acute care hospitals are normally recognised by the State/Territory health authority in the funding arrangements applying to those hospitals.

Private acute care hospitals:
Designated psychiatric units in private acute care hospitals normally require license or approval by the State/Territory health authority in order to receive benefits from health funds for the provision of psychiatric care.

Psychiatric hospitals:
Total psychiatric care days in stand-alone psychiatric hospitals are calculated by counting those days the patient received specialist psychiatric care. Leave days and days on which the patient was receiving other care (e.g. specialised intellectual ability or drug and alcohol care) should be excluded.

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

Community-based residential services:

Designated psychiatric units refers to 24-hour staffed Community-based residential units established in community settings that provide specialised treatment, rehabilitation or care for people affected by a mental illness or psychiatric disability. Special psychiatric units for the elderly are covered by this category, including psychogeriatric hostels or psychogeriatric nursing homes. Note that residences occupied by admitted patients located on hospital grounds, whether on the campus of a general or stand-alone psychiatric hospital, should be counted in the category of admitted patient services and not as Community-based residential services.

Counting of patient days and leave days in designated psychiatric units should follow the standard definitions applying to these items.

For each period of care in a designated psychiatric unit, total days is calculated by subtracting the date on which care commenced within the unit from the date on which the specialist unit care was completed, less any leave days that occurred during the period.

Total psychiatric care days in 24-hour Community-based residential care are calculated by counting those days the patient received specialist psychiatric care. Leave days and days on which the patient was receiving other care (e.g. specialised intellectual ability or drug and alcohol care) should be excluded.

Admitted patients in acute care:

Commencement of care within a designated psychiatric unit may be the same as the date the patient was admitted to the hospital, or occur subsequently, following transfer of the patient from another hospital ward. Where commencement of psychiatric care occurs by transfer from another ward, a new episode of care may be recorded, depending on whether the care type has changed (see data element Care type). Completion of care within a designated psychiatric unit may be the same as the date the patient was discharged from the hospital, or occur prior to this on transfer of the patient to another hospital ward. Where completion of psychiatric care is followed by transfer to another hospital ward, a new episode of care may be recorded, depending on whether the care type has changed (see data element Care type). Total psychiatric care days may cover one or more periods in a designated psychiatric unit within the overall hospital stay.

Accurate counting of total days in psychiatric care requires periods in designated psychiatric units to be identified in the person-level data collected by State or Territory health authorities. Several mechanisms exist for this data field to be implemented.

- Ideally, the new data field should be collected locally by hospitals and added to the unit record data provided to the relevant State/Territory health authority.
- Acute care hospitals in most States and Territories include details of the wards in which the patient was accommodated in the unit record data provided to the health authority. Local knowledge should be used to identify designated psychiatric units within each hospital's ward codes, to allow total psychiatric care days to be calculated for each episode of care.
- Acute care hospitals and 24-hour staffed Community-based residential services should be identified separately at the level of the establishment.

Verification rules: Total days in psychiatric care must be:
 >= zero; and
 <= length of stay

Collection methods:

Related metadata: is derived from Admission date vers 4
 is derived from Establishment type vers 1
 is derived from Separation date vers 5
 is derived from Total leave days vers 3
 supersedes previous data element Total psychiatric care days vers 1
 is derived from Care type vers 4

Administrative Attributes

Source document:

Source organisation: National Mental Health Information Strategy Committee

Information model link:

NHIM Performance indicator

Data Set Specifications:	Start date	End date
NMDS - Admitted patient care	01/07/1998	
NMDS - Admitted patient mental health care	01/07/1998	
NMDS - Community mental health care	01/07/2000	

Comments: This data element was originally designed to monitor trends in the delivery of psychiatric admitted patient care in acute care hospitals. It has been modified to enable collection of data in the Community-based residential care sector. The data element is intended to improve understanding in this area and contribute to the ongoing evaluation of changes occurring in mental health services.

Treatment delivery setting for alcohol and other drugs

Identifying and Definitional Attributes

Knowledgebase ID: 000646 **Version No:** 1

Metadata type: Data Element

Admin. status: Current
01/07/01

Definition: The setting in which the main treatment is provided.

Context: Alcohol and other drug treatment services:
Required to identify the settings in which treatment is occurring, allowing for trends in treatment patterns to be monitored.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

1	Non-residential treatment facility
2	Residential treatment facility
3	Home
4	Outreach setting
8	Other

Guide for use: Code 1 refers to any non-residential centre that provides alcohol and other drug treatment services, including hospital outpatient services and community health centres.

Code 2 refers to Community-based settings in which clients reside either temporarily or long-term in a facility that is not their home or usual place of residence, to receive alcohol and other drug treatment. This does not include ambulatory situations.

Code 3 refers to the client's own home or usual place of residence.

Code 4 refers to an outreach environment, excluding a client's home or usual place of residence, where treatment is provided. An outreach environment may be any public or private location that is not covered by codes 1-3.

Mobile/outreach alcohol and other drug treatment service providers would usually provide treatment within this setting.

Verification rules: Only one code to be selected.

Collection methods:

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 Service delivery setting

Data Set Specifications:

NMDS - Alcohol and other drug treatment services

Start date

End date

01/07/2001

Comments:

Treatment episode for alcohol and other drugs

Identifying and Definitional Attributes

Knowledgebase ID:	000647	Version No: 1
Metadata type:	Data Element Concept	
Admin. status:	Current	
	01/07/01	
Definition:	The period of contact, with defined dates of commencement and cessation, between a client and a treatment provider or team of providers that occurs in one setting and in which there is no change in the main treatment type or principal drug of concern, and there has not been a non-planned absence of contact for greater than 3 months.	
Context:	Alcohol and drug treatment services: This concept is required to provide the basis for a standard approach to recording and monitoring patterns of service utilisation by clients.	

Relational and Representational Attributes

Datatype:	
Representational form:	
Representational layout:	
Minimum size:	
Maximum size:	
Data domain:	
Guide for use:	
Verification rules:	
Collection methods:	
Related metadata:	<ul style="list-style-type: none"> relates to the data element 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 relates to the data element Date of cessation of treatment episode for alcohol and other drugs vers 2 relates to the data element Date of commencement of treatment episode for alcohol and other drugs vers 2 relates to the data element Main treatment type for alcohol and other drugs vers 1 relates to the data element Treatment delivery setting for alcohol and other drugs vers 1

Administrative Attributes

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

Triage category

Identifying and Definitional Attributes

Knowledgebase ID:	000355	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/98	
Definition:	The urgency of the patient's need for medical and nursing care.	
Context:	Emergency department care: Required to provide data for analysis of emergency department processes.	

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	N
Minimum size:	1
Maximum size:	1
Data domain:	<ul style="list-style-type: none"> 1 Resuscitation: immediate (within seconds) 2 Emergency: within 10 minutes 3 Urgent: within 30 minutes 4 Semi-urgent: within 60 minutes 5 Non-urgent: within 120 minutes

Guide for use:

Verification rules:

Collection methods: This triage classification is to be used in the emergency departments of hospitals. Patients will be triaged into one of five categories on the National Triage Scale according to the triageur's response to the question: 'This patient should wait for medical care no longer than ...?'

The triage category is allocated by an experienced registered nurse or medical practitioner. If the triage category changes, record the more urgent category.

Related metadata:

relates to the data element Admission date vers 4
relates to the data element Admission time vers 2
relates to the data element Date of service event vers 1
relates to the data element Date of triage vers 1
relates to the data element Date patient presents vers 2
relates to the data element Emergency department departure status vers 2
relates to the data element Emergency department waiting time to admission vers 1
relates to the data element Emergency department waiting time to service delivery vers 2
relates to the data element Non-admitted patient vers 1
relates to the data element concept Patient presentation at emergency department vers 1
relates to the data element Time of commencement of service event vers 2

relates to the data element Time of triage vers 1
 relates to the data element Time patient presents vers 2
 relates to the data element Type of visit to emergency department vers 2

Administrative Attributes

Source document: National Triage Scale, Australasian College for Emergency Medicine

Source organisation:

Information model link:

NHIM Assessment event

Data Set Specifications:

	<i>Start date</i>	<i>End date</i>
NMDS - Emergency department waiting times	01/07/1999	
NMDS - Non-admitted patient emergency department care	01/07/2003	

Comments: This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the NMDS - Emergency department waiting times.

Triglycerides – measured

Identifying and Definitional Attributes

Knowledgebase ID:	000658	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/01/03	
Definition:	A person's measured triglycerides.	
Context:	Public health, health care and clinical setting.	

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	NN.N
Minimum size:	3
Maximum size:	4

Data domain: Measurement in mmol/L to 1 decimal place
99.9 Not stated/inadequately described

Guide for use: Record the absolute result of the total triglyceride measurement.

Verification rules:

Collection methods: Measurement of lipid levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authorities.

- To be collected as a single venous blood sample, preferably following a 12-hour fast where only water and medications have been consumed.

Note that to calculate the low-density lipoprotein – cholesterol (LDL-C) from the Friedwald Equation (Friedwald et al. 1972):

- a fasting level of plasma triglyceride and knowledge of the levels of plasma total cholesterol and high-density lipoprotein – cholesterol (HDL-C) is required
- the Friedwald equation becomes unreliable when the plasma triglyceride exceeds 4.5 mmol/L and
- that while levels are reliable for the first 24 hours after the onset of acute coronary syndromes, they may be unreliable for the subsequent 6 weeks after an event.

(Lipid Management Guidelines – 2001, MJA 2001; 175: S57-S88. National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand.)

Related metadata: relates to the data element Cholesterol-total – measured vers 1
relates to the data element Cholesterol-HDL – measured vers 1
is used in the calculation of Cholesterol-LDL calculated vers 1
relates to the data element Dyslipidaemia – treatment vers 1
is used in conjunction with Fasting status vers 1
is used in conjunction with Service contact date vers 1
relates to the data element Waist circumference – measured vers 2

Administrative Attributes

Source document:

Source organisation: CV-Data Working Group

Information model link:

NHIM Assessment event

Data Set Specifications:

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

Comments:

DSS - Cardiovascular disease (clinical):

A relationship between triglyceride and HDL-C and chronic heart disease (CHD) event rates has been shown. This view is supported by the observation that the remnants of triglyceride-rich lipoproteins are the particles that occur in dysbetalipoproteinaemia, a condition associated with a very high risk of premature atherosclerotic vascular disease. There have been two comprehensive reviews of the relationship between plasma triglyceride and CHD (see Criqui et al. 1993 and Austin et al. 1991). Criqui concludes that triglyceride is not an independent predictor of CHD and is probably not causally related to the disease, while Austin provides a compelling case for a causal role of (at least) some triglyceride-rich lipoproteins. Conclusions drawn from population studies of the relationship between plasma triglyceride and the risk of CHD include the following:

- an elevated concentration of plasma triglyceride (> 2.0 mmol/L) is predictive of CHD when associated with either an increased concentration of LDL-C or a decreased concentration of HDL-C
- the relationship between CHD risk and plasma triglyceride is not continuous, with evidence that the risk is greatest in people with triglyceride levels between 2 and 6 mmol/L. (Lipid Management Guidelines – 2001, MJA 2001; 175: S57-S88. National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand.)

It is likely that the positive relationship between plasma triglyceride and CHD, as observed in many population studies, is because an elevated level of plasma triglyceride in some people is a reflection of an accumulation of the atherogenic remnants of chylomicrons and very low density lipoprotein. These particles are rich in both triglyceride and cholesterol and appear to be at least as atherogenic as LDL.

DSS - Diabetes (clinical):

Following Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus, the targets for lipids management is :

- to reduce total cholesterol to less than 5.5 mmol/L
- to reduce triglyceride level to less than 2.0 mmol/L
- to increase HDL-C to more than or equal to 1.0 mmol/L.

Alterations in fat transport, often resulting in hyper-triglyceridaemia, are well-recognised concomitants of diabetes mellitus.

Elevated plasma triglyceride levels are present in about one third of diabetic patients. It seems that triglycerides are related to the critical role of insulin in the production and removal from plasma of triglyceride-rich lipoproteins.

Lifestyle modifications, including weight loss and reduction of excess alcohol intake, are particularly effective for reducing triglyceride and increasing HDL-C.

References:

National Heart Foundation of Australia – Lipid Management Guidelines 2001. Hypertriglyceridaemia; Australian Medicines Handbook.

Tumour size at diagnosis – solid tumours

Identifying and Definitional Attributes

Knowledgebase ID:	000778	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/02	
Definition:	The largest dimension of a solid tumour, measured in millimetres.	
Context:	This is used to measure the diameter of the largest dimension of breast cancers and other solid neoplasms for patient management, population cancer statistics and research.	

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	NNN
Minimum size:	3
Maximum size:	3
Data domain:	Size in millimetres with valid values 001 to 997 999 Unknown

Guide for use: The reporting standard for the size of solid tumours is:
Breast cancer or other solid neoplasms – the largest tumour dimension, measured to a precision of 1 mm.

Verification rules:

Collection methods:

Related metadata:

Administrative Attributes

Source document:

Source organisation:

Information model link:

NHIM Request for/entry into service event

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

Comments:

Tumour thickness at diagnosis – melanoma

Identifying and Definitional Attributes

Knowledgebase ID:	000779	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/02	
Definition:	The measured thickness of a melanoma in millimetres.	
Context:	Patient management, population cancer statistics and research.	

Relational and Representational Attributes

Datatype:	Numeric		
Representational form:	Quantitative value		
Representational layout:	NNN.NN		
Minimum size:	6		
Maximum size:	6		
Data domain:	Size in millimetres – valid values are: 000.01 to 997.99 999.99 Unknown		
Guide for use:	The reporting standard for the thickness of melanoma is: Primary cutaneous melanoma – the depth of penetration of tumour cells below the basal layer of the skin; measured to a precision of 0.01 mm.		
Verification rules:			
Collection methods:			
Related metadata:			

Administrative Attributes

Source document:			
Source organisation:			
Information model link:			
NHIM Request for/entry into service event			
Data Set Specifications:	Start date	End date	

Comments:

Type and sector of employment establishment

Identifying and Definitional Attributes

Knowledgebase ID:	000166	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/95	
Definition:	<p>For each health profession, type of employment establishment is a self-reporting, condensed industry of employment classification that can be cross-referenced to the Australian and New Zealand Standard Industrial Classification.</p> <p>Sector of employment establishment is government (public) or non-government (private), according to whether or not the employer is a Commonwealth, State or local government agency.</p>	
Context:	<p>Health labour force:</p> <p>To analyse distribution of service providers by setting (defined by industry of employer and sector), cross-classified with main type of work and/or specialty area.</p>	

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	NN
Minimum size:	2
Maximum size:	2
Data domain:	<ul style="list-style-type: none"> 01 Private medical practitioner rooms/surgery (including 24-hour medical clinics) 02 Other public non-residential health care facility (e.g. Aboriginal health service, ambulatory centre, outpatient clinic, day surgery centre, medical centre, community health centre) 03 Other private non-residential health care (e.g. Aboriginal health service, ambulatory centre, outpatient clinic, day surgery centre, medical centre, community health centre) 04 Hospital – acute care (including psychiatric or specialist hospital) hospital (public) 05 Hospital – acute care (including psychiatric or specialist hospital) hospital (private) 06 Residential health care (e.g. nursing home, hospice, physical disabilities residential centre) facility (public) 07 Residential health care (e.g. nursing home, hospice, physical disabilities residential centre) facility (private) 08 Tertiary education institution (public) 09 Tertiary education institution (private) 10 Defence forces 11 Government department or agency (e.g. laboratory, research organisation etc.) 12 Private industry/private enterprise (e.g. insurance, pathology, bank)

- 13 Other (specified) public
- 14 Other (specified) private
- 99 Unknown/inadequately described/not stated

Guide for use:

Establishments are coded into self reporting groupings in the public and private sectors. This can be seen in the code list for medical practitioners.

Minor variations in ordering of sequence and disaggregation of the principal categories will be profession-specific as appropriate; where a more detailed set of codes is used, the essential criterion is that there should not be an overlap of the detailed codes across the Australian and New Zealand Standard Industrial Classification category definitions.

Note:

Public psychiatric hospitals are non-acute care facilities, whereas private psychiatric hospitals are acute care facilities. To minimise the possibility of respondent confusion and misreporting, public psychiatric hospitals are included in the grouping for acute care public hospitals.

Day surgery centres, outpatient clinics and medical centres approved as hospitals under the *Health Insurance Act 1973* (Commonwealth) have emerged as a new category for investigation. These will be included in a review of the National Health Labour Force Collection questions and coding frames.

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

Source organisation: National Health Labour Force Data Working Group

Information model link:

NHIM Organisational setting

Data Set Specifications:

NMDS - Health labour force

Start date

End date

01/07/1995

Comments:

Type of accommodation

Identifying and Definitional Attributes

Knowledgebase ID:	000173	Version No: 2
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/99	
Definition:	The type of accommodation setting in which the person usually lives/lived.	

Context:	Admitted patient mental health care:
	Permits analysis of the usual residential accommodation type of people prior to admission to institutional health care. The setting in which the person usually lives can have a bearing on the types of treatment and support required by the person and the outcomes that result from their treatment.

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Code
Representational layout:	N(N)
Minimum size:	1
Maximum size:	2

Data domain:	1	Private residence (e.g. house, flat, bedsitter, caravan, boat, independent unit in retirement village), including privately and publicly rented homes
	10	Other supported accommodation
	11	Prison/remand centre/youth training centre
	12	Public place (homeless)
	13	Other accommodation, not elsewhere classified
	14	Unknown/unable to determine
	2	Psychiatric hospital
	3	Residential aged care service
	4	Specialised alcohol/other drug treatment residence
	5	Specialised mental health Community-based residential support service
	6	Domestic-scale supported living facility (e.g. group home for people with disabilities)
	7	Boarding/rooming house/hostel or hostel type accommodation, not including aged persons' hostel
	8	Homeless persons' shelter
	9	Shelter/refuge (not including homeless persons' shelter)

Guide for use:	'Usual' is defined as the type of accommodation the person has lived in for the most amount of time over the past three months prior to admission to institutional health care or first contact with a community service setting. If a person stays in a particular place of accommodation for four or more days a week over the period, that place of accommodation would be the person's type of usual accommodation. In practice, receiving an answer strictly in accordance with the above definition may be difficult to achieve. The place the person
-----------------------	---

perceives as their usual accommodation will often prove to be the best approximation of their type of usual accommodation.

3 - Includes nursing home beds in acute care hospitals.

4 - Includes alcohol/other drug treatment units in psychiatric hospitals.

5 - Specialised mental health Community-based residential support services are defined as Community-based residential supported accommodation specifically targeted at people with psychiatric disabilities which provides 24-hour support/rehabilitation on a residential basis.

6 - Domestic-scale supported living facilities include group homes for people with disabilities, cluster apartments where a support worker lives on-site, community residential apartments (except mental health), congregate care arrangements. Support is provided by staff on either a live-in or rostered basis, and they may or may not have 24-hour supervision and care.

10 - Includes other supported accommodation facilities such as hostels for people with disabilities and Residential Services/Facilities (Victoria and South Australia only). These facilities provide board and lodging and rostered care workers provide client support services.

Verification rules:

Collection methods:

Related metadata: is an alternative to Type of usual accommodation vers 1

Administrative Attributes

Source document:

Source organisation: National Health Data Committee

Information model link:

NHIM Accommodation characteristic

Data Set Specifications:

NMDS - Admitted patient mental health care

Start date

End date

01/07/1999

Comments:

The changes made to this data element are in accordance with the requirements of the National Mental Health Information Strategy Committee and take into consideration corresponding definitions in other data dictionaries (e.g. HACC Data Dictionary Version 1 and National Community Services Data Dictionary Version 1).

Type of augmentation of labour

Identifying and Definitional Attributes

Knowledgebase ID: 000167 **Version No:** 2

Metadata type: Data Element

Admin. status: Current
01/07/00

Definition: Methods used to assist progress of labour.

Context: Perinatal care:
Type of augmentation determines the progress and duration of labour and may influence the method of delivery and the health status of the baby at birth.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

0	None
1	Oxytocin
2	Prostaglandins
3	Artificial rupture of membranes
4	Other
5	Not stated

Guide for use: More than one method of augmentation can be recorded, except where 0=none applies.

Verification rules: Collection units need to edit carefully the use of prostaglandins as an augmentation method. Results from checking records have shown that either the onset of labour was incorrect or that the augmentation method was incorrectly selected.

Collection methods:

Related metadata:

- is used in conjunction with Method of birth vers 1
- is used in conjunction with Onset of labour vers 2
- supersedes previous data element Type of augmentation 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****Comments:**

Prostaglandin is listed as a method of augmentation in the data domain. Advice from Royal Australia and New Zealand College of Obstetricians and Gynaecologists and the manufacturer indicates that vaginal prostaglandin use is not recommended or supported as a method of augmentation of labour as it may significantly increase the risk of uterine hyperstimulation. In spite of this, the method is being used and it is considered important to monitor its use for augmentation.

Type of labour induction

Identifying and Definitional Attributes

Knowledgebase ID: 000171 **Version No:** 1

Metadata type: Data Element

Admin. status: Current
01/07/96

Definition: Methods used to induce labour.

Context: Perinatal statistics:
Type of induction determines the progress and duration of labour and may influence the method of delivery and the health status of the baby at birth.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Code

Representational layout: N

Minimum size: 1

Maximum size: 1

Data domain:

0	None
1	Oxytocin
2	Prostaglandins
3	Artificial rupture of membranes
4	Other

Guide for use: More than one method of induction can be recorded, except where 0=none applies.

Verification rules:

Collection methods:

Related metadata: is used in conjunction with Onset of labour vers 2
is used in conjunction with Type of augmentation of labour vers 2

Administrative Attributes

Source document:

Source organisation: National Perinatal Data Development Committee

Information model link:

NHIM Birth event

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

Comments:

Type of non-admitted patient care

Identifying and Definitional Attributes

Knowledgebase ID:	000231	Version No: 1
Metadata type:	Derived Data Element	
Admin. status:	Current	
	01/07/94	
Definition:	This data element identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.	
Context:	Required to describe the broad types of services provided to non-admitted patients, community patients and outreach clients.	

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	NNNNNNN
Minimum size:	1
Maximum size:	7
Data domain:	Count of number of non-admitted patient occasions of service.
Guide for use:	<p>A count is required for each of the following categories (definitions of each are given below):</p> <p>Emergency department and emergency services:</p> <ul style="list-style-type: none"> A9.1 Emergency services <p>Outpatient services:</p> <ul style="list-style-type: none"> A9.2 Dialysis A9.3 Pathology A9.4 Radiology and organ imaging A9.5 Endoscopy and related procedures A9.6 Other medical/surgical/diagnostic A9.7 Mental health A9.8 Drug and alcohol A9.9 Dental A9.10 Pharmacy A9.11 Allied health services <p>Other non-admitted services:</p> <ul style="list-style-type: none"> A9.12 Community health services A9.13 District nursing services A9.14 Other outreach services

Definitions:**A9.1 Emergency services:**

Services to patients who are not admitted and who receive treatment that was either unplanned or carried out in designated emergency departments within a hospital. Unplanned patients are patients who have not been booked into the hospital before receiving treatment. In general it would be expected that most patients would receive surgical or medical treatment. However, where patients receive other types of treatment that are provided in emergency departments these are to be included. The exceptions are for dialysis and endoscopy and related procedures which have been recommended for separate counting.

A9.2 Dialysis:

This represents all non-admitted patients receiving dialysis within the establishment. Where patients receive treatment in a ward or clinic classified elsewhere (for example, an emergency department), those patients are to be counted as dialysis patients and to be excluded from the other category. All forms of dialysis which are undertaken as a treatment necessary for renal failure are to be included.

A9.3 Pathology:

This includes all occasions of service to non-admitted patients from designated pathology laboratories. Occasions of service to all patients from other establishments should be counted separately.

A9.4 Radiology and organ imaging:

This includes all occasions of service to non-admitted patients undertaken in radiology (X-ray) departments as well as in specialised organ imaging clinics carrying out ultrasound, computerised tomography and magnetic resonance imaging.

A9.5 Endoscopy and related procedures:

This should include all occasions of service to non-admitted patients for endoscopy including:

- cystoscopy
- gastroscopy
- oesophagoscopy
- duodenoscopy
- colonoscopy
- bronchoscopy
- laryngoscopy.

Where one of these procedures is carried out in a ward or clinic classified elsewhere, for example in the emergency department, the occasion is to be included under endoscopy and related procedures, and to be excluded from the other category. Care must be taken to ensure procedures on admitted patients are excluded from this category.

A9.6 Other medical/surgical/diagnostic:

Any occasion of service to a non-admitted patient given at a designated unit primarily responsible for the provision of medical/surgical or diagnostic services which has not been covered in the above. These include ECG, obstetrics, nuclear medicine, general medicine, general surgery, fertility and so on.

A9.7 Mental health:

All occasions of service to non-admitted patients attending designated psychiatric or mental health units within hospitals.

A9.8 Alcohol and drug:

All occasions of service to non-admitted patients attending designated drug and alcohol units within hospitals.

A9.9 Dental:

All occasions of service to non-admitted patients attending designated dental units within hospitals.

A9.10 Pharmacy:

This item includes all occasions of service to non-admitted patients from pharmacy departments. Those drugs dispensed/administered in other departments such as the emergency department, or outpatient departments, are to be counted by the respective departments.

A9.11 Allied health services:

This includes all occasions of service to non-admitted patients where services are provided at units/clinics providing treatment/counselling to patients. These include units primarily concerned with physiotherapy, speech therapy, family planning, dietary advice, optometry, occupational therapy and so on.

A9.12 Community health services:

Occasions of service to non-admitted patients provided by designated community health units within the establishment. Community health units include:

- baby clinics
- immunisation units
- aged care assessment teams
- other.

A9.13 District nursing service: Occasions of service to non-admitted patients which:

- are for medical/surgical/psychiatric care
- are provided by a nurse, paramedic or medical officer
- involve travel by the service provider*
- are not provided by staff from a unit classified in the community health category above.

A9.14 Other outreach services: Occasions of service to non-admitted patients which:

- involve travel by the service provider*
- are not classified in allied health or community health services above.

* Travel does not include movement within an establishment, movement between sites in a multi-campus establishment or between establishments. Such cases should be classified under the appropriate non-admitted patient category.

It is intended that these activities should represent non-medical/surgical/psychiatric services. Activities such as home cleaning, meals on wheels, home maintenance and so on should be included.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

Verification rules:**Collection methods:**

The list of categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Related metadata:**Administrative Attributes****Source document:****Source organisation:** National minimum data set working parties**Information model link:**

NHIM - Performance indicator

Data Set Specifications:

NMDS - Public hospital establishments

Start date**End date**

01/07/1994

Comments:

Outreach/community care is care delivered by hospital employees to the patient in the home, place of work or other non-hospital site. The distinction between non-admitted patient care and outreach care is that for non-admitted patient care the patients travel to the health care providers while for outreach care the health care providers travel to the patients. This distinction creates difficulties for community health centres. These centres are to be included in the national minimum data set where they are funded as sections within establishments that fall within the scope of the National Health Data Dictionary. For example, baby clinics, immunisation groups or aged care assessment teams, which are funded through acute hospitals, may provide care to some clients within the hospital grounds or externally. It is intended that all community health activity be measured under community health regardless of where the services are provided.

Type of non-admitted patient care (public psychiatric, alcohol and drug)

Identifying and Definitional Attributes

Knowledgebase ID: 000233 **Version No:** 1

Metadata type: Derived Data Element

Admin. status: Current
01/07/89

Definition: Emergency patients and outpatients are persons who receive non-admitted care. Non-admitted care is care provided to a person who receives direct care within the emergency department or other designated clinics within the hospital and who is not formally admitted at the time when the care is provided. A person who first contacts the hospital and receives non-admitted care, for example through the emergency department, and is subsequently admitted should have both components of care enumerated separately.

For outreach/community patients, care delivered by hospital employees to the patient in the home, place of work or other non-hospital site.

A group is defined as two or more patients receiving a service together, where all individuals are not members of the same family. Family services are to be treated as occasions of service to an individual.

Context: Required to adequately describe the services provided to non-admitted patients in public psychiatric hospitals and alcohol and drug hospitals.

Relational and Representational Attributes

Datatype: Numeric

Representational form: Quantitative value

Representational layout: NNNNNNN

Minimum size: 1

Maximum size: 7

Data domain: Count occasions of service for each of the categories.

Guide for use: A count is required for each of the following categories:

Emergency and outpatient occasions of service:

- 1 Individual patients
- 2 Groups

Outreach/community occasions of service:

- 3 Individual patients
- 4 Groups

Verification rules:

Collection methods: The working party discussed the need to distinguish different types of psychiatric outpatient services in psychiatric hospitals. South Australia outlined its categories of psychiatric outpatients:

- day patients (not admitted but are day program patients)
- outpatients (typically 20 minutes consultation)
- community/outreach (outreach services provided by staff off the hospital site, including community health service provided off-site and domiciliary care)

- casualty patients (designated casualty area, mirroring usual hospital set up).

These categories also applied to mental health clinics in South Australia. The working party agreed that the South Australian categories were useful, but that outpatient and casualty categories should be collapsed as there was a boundary problem between these two categories.

The working party initially recommended the following categories for activity data for outpatient services at establishment level:

- day program patients
- emergency and other outpatients
- outreach/community.

The first two of the above categories cover all outpatients treated on the hospital site, the latter covers outreach services provided by the staff off the hospital site. It includes community health services provided by hospital staff off-site.

The working party then discussed the unit of counting for activity data. The Psychiatric Working Party reviewed the recommendation of the Inpatient/Non-inpatient Working Party that occasions of service should be the appropriate unit of counting. The following points were raised:

- The method of counting the number of group sessions in a psychiatric setting was difficult because a day patient is always a group patient. Also, groups would have a mixture of inpatients and outpatients.
- Counting occasions of service for a day patient was difficult because a patient could have up to eight treatment encounters in one day.
- From a client perspective, groups should be ignored and information should be collected on every individual.
- Queensland counted the number of days on which contact is made, irrespective of intensity of service.
- It was suggested that occasions of service (or individuals) be counted but that the information should be divided into one-on-one sessions or group sessions, for resource implications.
- Some members thought that, in terms of resources, groups of staff and type of provider were more important than number of clients.
- Victoria proposed a bare-bones approach, and recommended that only occasions of service be counted. All the other points raised were important dimensions, but Victoria felt that to do justice to them, it would be necessary to include community services, phone consultations and so on, which was not feasible at this stage.
- The Psychiatric Working Party foreshadowed the need to categorise outpatients further into child, adult and other. It was generally agreed that while this aspect would be worthwhile flagging in a policy statement, it was not necessary to consider it at this stage.
- The Psychiatric Working Party also agreed that occasions of service was the preferred counting unit for non-admitted patient activity data. It was noted that the acute sector had opted for this unit.
- The Psychiatric Working Party recommended that a family was to be counted as one occasion of service (individual session) not as a group, and that a family unit was to be determined as a group of people which identified themselves as such.

The Psychiatric Working Party agreed that the unit of counting of services should be as follows:

- day program attendances
- other outpatient occasions of service
- outreach occasions of service.

Day program patients should be counted as number of attendances to a day program (patient days). Day program patient occasions of service with other staff should be counted separately as other outpatient occasions of service.

Related metadata:**Administrative Attributes****Source document:****Source organisation:** National minimum data set working parties**Information model link:**

NHIM Performance indicator

Data Set Specifications:

NMDS - Public hospital establishments

Start date**End date**

01/07/1989

Comments:

In general, establishments other than acute hospitals provide a much more limited range of services for non-admitted patients and outreach/community patients/clients. Therefore, disaggregation by type of non-admitted patient care is not relevant to psychiatric and alcohol/drug hospitals.

Type of non-admitted patient care (residential aged care services)

Identifying and Definitional Attributes

Knowledgebase ID:	000234	Version No: 1
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/89	
Definition:	<p>Outpatients are patients who receive non-admitted care. Non-admitted care is care provided to a patient who is not formally admitted but receives direct care from a designated clinic within the residential aged care service.</p> <p>For outreach/community patients, care is delivered by residential aged care service employees to the patient in the home, place of work or other non-establishment site.</p>	
Context:	<p>Non-admitted patient care:</p> <p>Required to adequately describe the services provided to non-admitted patients.</p>	

Relational and Representational Attributes

Datatype:	Numeric
Representational form:	Quantitative value
Representational layout:	NNN
Minimum size:	1
Maximum size:	3
Data domain:	Count of occasions of service.
Guide for use:	<p>Count to be recorded for each of the following categories:</p> <p>A11.1 Service to outpatients</p> <p>A11.2 Service to outreach/community patients</p>

Verification rules:

Collection methods:

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
---------------------------------	-------------------	-----------------

Comments: Apart from acute hospitals, establishments generally provide a much more limited range of services for non-admitted patients and outreach/community patients/clients. Therefore disaggregation by type of episode is not as necessary as in acute hospitals.

Type of usual accommodation

Identifying and Definitional Attributes

Knowledgebase ID:	000173	Version No:	1
Metadata type:	Data Element		
Admin. status:	Current		
	01/07/89		
Definition:	The type of physical accommodation the person lived in prior to admission.		
Context:	Admitted patient mental health care:		
	Permits analysis of the prior residential accommodation type of people admitted to residential aged care services or other institutional care.		

Relational and Representational Attributes

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

Data domain:	1	House or flat
	2	Independent unit as part of retirement village or similar
	3	Hostel or hostel type accommodation
	4	Psychiatric hospital
	5	Acute hospital
	6	Other accommodation
	7	No usual residence

Guide for use:

Verification rules:

Collection methods: The above classifications have been based on Question 16 of Form NH5. This item is not available for New South Wales State nursing homes.

As this data item includes only details of physical accommodation before admission it was decided to have details of the relational basis of accommodation before admission collected as a separate data element (see data element Mode of admission). The Commonwealth Department of Health and Ageing has introduced a new Aged Care Application and Approval form which replaces the NH5.

Related metadata: is an alternative to Type of accommodation vers 2

Administrative Attributes

Source document:

Source organisation: National minimum data set working parties

Information model link:

NHIM Accommodation characteristic

Data Set Specifications:

NMDS - Admitted patient mental health care

Start date **End date**

01/07/1997

Comments:

Type of visit to emergency department

Identifying and Definitional Attributes

Knowledgebase ID:	000352	Version No: 2
Metadata type:	Data Element	
Admin. status:	Current	
	01/07/01	
Definition:	The reason the patient presents to the emergency department.	
Context:	Hospital non-admitted patient care: Required for analysis of emergency department services.	

Relational and Representational Attributes

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

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

Guide for use:

Verification rules:

Collection methods:

Related metadata:	relates to the data element Emergency department waiting time to admission vers 1
	relates to the data element Emergency department waiting time to service delivery vers 2
	relates to the data element concept Patient presentation at emergency department vers 1
	relates to the data element Triage category vers 1
	supersedes previous data element Type of visit vers 1

Administrative Attributes

Source document:

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

Information model link:

NHIM Request for/entry into service event

Data Set Specifications:

NMDS - Emergency department waiting times

Start date**End date**

01/07/2001

NMDS - Non-admitted patient emergency department care

01/07/2003

Comments:

This data element supports the provision of unit record and/or summary level data by State and Territory health authorities as part of the NMDS - Emergency department waiting times.