

Electrocardiogram (ECG) change — location

Identifying and definitional attributes

Knowledgebase ID: 001037 **Version number:** 1
Metadata type: Data element

Definition: Describes the area in which the change is located on the 12-lead electrocardiogram (ECG).
Context: Health care and clinical settings.

Relational and representational attributes

Data type: Numeric **Maximum field size:** 1
Representational class: Code **Format:** N

Data domain:

1	Inferior leads: II, III, aVF
2	Anterior leads: V1 to V4
3	Lateral leads: I, aVL, V5 to V6
4	True posterior: V1 V2
8	None
9	Not stated/inadequately described

Guide for use: Code 4 True posterior is relevant only for tall R waves.
 More than one code may be recorded.
 Report in order of significance.
 Record all codes that apply (codes 8 and 9 are excluded from multiple coding).

Verification rules:

Collection methods:

Related metadata: Used in conjunction with the data element Electrocardiogram (ECG) change — type, version 1.

Information model link: NHIM Service provision event

Data set specifications:	Start date	End date
DSS — Acute coronary syndrome (clinical)	04/06/2004	

Administrative attributes

Admin. status: CURRENT **Effective Date:** 04/06/2004

Source organisation: Acute Coronary Syndrome Data Working Group.

Source document:

Registration authority: National Health Information Group.

Steward: The National Heart Foundation of Australia.
The Cardiac Society of Australia and New Zealand.

Comments:

Electrocardiogram (ECG) change—type

Identifying and definitional attributes

Knowledgebase ID: 001038 **Version number:** 1
Metadata type: Data element

Definition: Describes the type of change to the heart rhythm seen on the electrocardiogram (ECG).
Context: Acute coronary syndrome treatment settings.

Relational and representational attributes

Data type: Numeric **Maximum field size:** 1
Representational class: Code **Format:** N

Data domain:	1	ST-segment elevation \geq 1 mm (0.1 mV) in \geq 2 contiguous limb leads
	2	ST-segment elevation \geq 2 mm (0.2 mV) in \geq 2 contiguous chest leads
	3	ST-segment depression \geq 0.5 mm (0.05 mV) in \geq 2 contiguous leads (includes reciprocal changes)
	4	\geq Significant Q waves
	5	Bundle branch block (BBB)
	6	Non-specific
	7	No changes
	9	Not stated/inadequately described

Guide for use: For Acute coronary syndrome (ACS) reporting, used to determine diagnostic strata.
 More than one code may be recorded.
 Record all that apply (codes 7, 8 and 9 are excluded from multiple coding).

Code 1 ST-segment elevation indicates greater than or equal to 1 mm (0.1 mV) elevation in 2 or more contiguous limb leads

Code 2 ST-segment elevation indicates greater than or equal to 2 mm (0.2 mV) elevation in 2 or more contiguous chest leads

Code 3 ST-segment depression of at least 0.5 mm (0.05 mV) in 2 or more contiguous leads (includes reciprocal changes)

Code 4 T-wave inversion of at least 1 mm (0.1 mV) including inverted T waves that are not indicative of acute MI

Code 5 Q waves refer to the presence of Q waves that are greater than or equal to 0.03 seconds in width and greater than or equal to 1 mm (0.1 mV) in depth in at least 2 contiguous leads

Code 6 Bundle branch block pattern

Code 7 Changes not meeting the above criteria

Code 8 No ECG changes

Code 9 includes unknown

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

Is a qualifier of Acute coronary syndrome stratum, version 1.
 Is used in conjunction with the data element Acute coronary syndrome procedure type, version 1.
 Is used in conjunction with Electrocardiogram (ECG) change – location, version 1.
 Is used in conjunction with Date of triage, version 1.
 Is used in conjunction with Time of triage, version 1.

Information model link: NHIM Service provision event

Data set specifications:

DSS – Acute coronary syndrome (clinical)

Start date

04/06/2004

End date**Administrative attributes****Admin. status:**

CURRENT

Effective Date:

04/06/2004

Source organisation:

Acute Coronary Syndrome Data Working Group.

Source document:**Registration authority:**

National Health Information Group.

Steward:

The National Heart Foundation of Australia.
 The Cardiac Society of Australia and New Zealand.

Comments:

Episode of residential care

Identifying and definitional attributes

Knowledgebase ID: 000891 **Version number:** 1
Metadata type: Data element concept

Definition: The period of care between the start of residential care (either through the formal start of the residential stay or the start of new reference period) and the end of the residential care (either through the formal end of residential care, commencement of leave intended to be greater than seven days or the end of the reference period).

Context: Specialised mental health services (Residential mental health care).

Relational and representational attributes

Data type: **Maximum field size:**
Representational class: **Format:**

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related metadata: Relates to the data element concept Episode of residential care end, version 1.
 Relates to the data element concept Episode of residential care start, version 1.
 Relates to the data element concept Resident, version 1.
 Relates to data element Episode of residential care end date, version 1.
 Relates to data element Episode of residential care start date, version 1.
 Relates to data element Residential stay start date, version 1.

Information model link: NHIM Service provision event

Data set specifications: **Start date** **End date**
 NMDS – Residential mental health care 01/07/2004

Administrative attributes

Admin. status: CURRENT **Effective Date:** 14/11/2003

Source organisation:

Source document:

Registration authority: National Health Information Group.

Steward:

Comments:

For residents provided with care intended to be on an overnight basis. This may occasionally include episodes of residential care that unexpectedly ended on the same day as they started (for example, the resident died or left against advice) or began at the end of the reference period (i.e. starting care on 30 June).

Episode of residential care end

Identifying and definitional attributes

Knowledgebase ID: 000893 *Version number:* 1

Metadata type: Data element concept

Definition:	<p>Episode of residential care end is the administrative process by which a residential care service either records:</p> <p>Formal episode of residential care end</p> <ul style="list-style-type: none"> - The formal end of residential care and accommodation of a resident, - The end of residential care and accommodation of a resident who has commenced leave where there is no intention that the resident returns to residential care within seven days, or <p>Statistical episode of residential care end</p> <ul style="list-style-type: none"> - The end of the reference period.
Context:	Specialised mental health services (Residential mental health care).

Relational and representational attributes

Data type: *Maximum field size:*

Representational class: *Format:*

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related metadata:

- Relates to the data element concept Episode of residential care start, version 1.
- Relates to the data element concept Resident, version 1.
- Relates to the data element Episode of residential care end date, version 1.

Information model link: NHIM Exit/leave from service event

Administrative attributes

Admin. status: CURRENT *Effective Date:* 14/11/2003

Source organisation:

Source document:

Registration authority: National Health Information Group.

Steward:

Comments:

Episode of residential care end date

Identifying and definitional attributes

Knowledgebase ID: 000894 **Version number:** 1
Metadata type: Data element

Definition: Date on which a resident formally or statistically ends an episode of residential care.

Context: Specialised mental health services (Residential mental health care).

Relational and representational attributes

Data type: Numeric **Maximum field size:** 8
Representational class: Date **Format:** DDMMYYYY

Data domain: Valid date.

Guide for use:

Verification rules: Data in this field must be:

- less than or equal to last day of reference period
- greater than or equal to first day of reference period
- greater than or equal to Episode of residential care start date

Collection methods:

Related metadata: Relates to the data element concept Episode of residential care end, version 1.
 Relates to the data element concept Episode of residential care, version 1.
 Relates to the data element concept Resident, version 1.

Information model link: NHIM Exit/leave from service event

Data set specifications:	Start date	End date
NMDS – Residential mental health care	01/07/2004	

Administrative attributes

Admin. status: CURRENT **Effective Date:** 14/11/2003

Source organisation:

Source document:

Registration authority: National Health Information Group.

Steward:

Comments:

Episode of residential care end mode

Identifying and definitional attributes

Knowledgebase ID: 000895 **Version number:** 1
Metadata type: Data element

Definition:	Reason for end of episode of residential care.
Context:	Specialised mental health services (Residential mental health care).

Relational and representational attributes

Data type: Numeric **Maximum field size:** 1
Representational class: Code **Format:** N

Data domain:	Formal episode of residential care end
	1 Died
	2 Left against clinical advice/at own risk
	3 Commenced leave where there is no intention that the resident returns to overnight residential care within seven days
	4 Other end of residential care at this establishment
	Statistical episode of residential care end
	5 End of reference period
	Other
	9 Unknown/not stated/inadequately described

Guide for use:

Verification rules:

Collection methods:

Related metadata: Is supplemented by the data element Referral from specialised mental health residential care, version 1.

Information model link: NHIM Exit/leave from service event

Data set specifications:	Start date	End date
NMDS – Residential mental health care	01/07/2004	

Administrative attributes

Admin. status: CURRENT **Effective Date:** 14/11/2003

Source organisation:

Source document:

Registration authority: National Health Information Group.

Steward:

Comments:

Episode of residential care start

Identifying and definitional attributes

Knowledgebase ID: 000896 *Version number:* 1

Metadata type: Data element concept

Definition:

Episode of residential care start is the process whereby the residential care service accepts responsibility for the Resident's residential care and accommodation. Episode of residential care start is the administrative process by which a residential care service records either:

Formal episode of residential care start

- The start of residential care and accommodation of a resident, and,
- The unplanned return from leave of a resident (when there had been no intention of returning to overnight residential care within seven days), or

Statistical episode of residential care start

- The start of a reference period for a resident continuing their residential care and accommodation, from the previous reference period.

Context:

Relational and representational attributes

Data type: *Maximum field size:*

Representational class: *Format:*

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related metadata: Relates to the data element concept Episode of residential care end, version 1.

Relates to the data element concept Resident, version 1.

Relates to the data element Episode of residential care start date, version 1.

Information model link: NHIM Request for/entry into service event

Administrative attributes

Admin. status: CURRENT *Effective Date:* 14/11/2003

Source organisation:

Source document:

Registration authority: National Health Information Group.

Steward:

Comments:

Episode of residential care start date

Identifying and definitional attributes

Knowledgebase ID: 000897 **Version number:** 1
Metadata type: Data element

Definition:	Date on which the resident starts an episode of residential care either because of: Formal episode of residential care start <ul style="list-style-type: none"> - The start of treatment and/or care and accommodation of a resident, or Statistical episode of residential care start <ul style="list-style-type: none"> - The start of a reference period for a resident continuing their treatment and/or care and accommodation from the previous reference period.
Context:	Specialised mental health services (Residential mental health care).

Relational and representational attributes

Data type: Numeric **Maximum field size:** 8
Representational class: Date **Format:** DDMMYYYY

Data domain:	Valid date.
---------------------	-------------

Guide for use:

Verification rules: Right justified and zero filled.
 Episode of residential care start date must be less than or equal to episode of residential care end date.
 Episode of residential care start date must be greater than or equal to date of birth.

Collection methods:

Related metadata: Relates to the data element concept Episode of residential care start, version 1.
 Relates to the data element concept Resident, version 1.
 Relates to the data element concept Episode of residential care, version 1.

Information model link: NHIM Request for/entry into service event

Data set specifications:	Start date	End date
NMDS – Residential mental health care	01/07/2004	

Administrative attributes

Admin. status: CURRENT

Effective Date: 14/11/2003

Source organisation:

Source document:

Registration authority: National Health Information Group.

Steward:

Comments:

Episode of residential care start mode

Identifying and definitional attributes

Knowledgebase ID: 000898 **Version number:** 1
Metadata type: Data element

Definition:	Reason for start of episode of residential care.
Context:	Specialised mental health services (Residential mental health care).

Relational and representational attributes

Data type: Numeric **Maximum field size:** 1
Representational class: Code **Format:** N

Data domain:	Formal episode of residential care start
	1 Unplanned return from leave where there had been no intention that the resident would return to overnight residential care at the establishment within seven days
	2 Other (i.e. start of a new residential stay)
	Statistical episode of residential care start
	3 Start of a new reference period
	Other
	9 Unknown/not stated/inadequately described

Guide for use:

Verification rules:

Collection methods:

Related metadata: Is supplemented by the data element Source of mental health service transfer to residential care, version 1.

Information model link: NHIM Exit/leave from service event

Data set specifications:	Start date	End date
NMDS – Residential mental health care	01/07/2004	

Administrative attributes

Admin. status: CURRENT **Effective Date:** 14/11/2003

Source organisation:

Source document:

Registration authority: National Health Information Group.

Steward:

Comments:

Fibrinolytic drug used

Identifying and definitional attributes

Knowledgebase ID: 001039 **Version number:** 1
Metadata type: Data element

Definition: Identifies the fibrinolytic drug used.
Context: Health care and clinical settings.

Relational and representational attributes

Data type: Numeric **Maximum field size:** 1
Representational class: Code **Format:** N

Data domain:

1	Streptokinase
2	t-PA (Tissue Plasminogen Activator) (Alteplase)
3	r-PA (Retepase)
4	TNK t-PA (Tenecteplase)
9	Not stated/ inadequately described

Guide for use: For Acute coronary syndrome (ACS) reporting, this data element pertains to the administering of fibrinolytic therapy drugs at any time point during this current event.

Verification rules:

Collection methods:

Related metadata: Is used in conjunction with Date of intravenous fibrinolytic therapy, version 1.
 Is used in conjunction with Time of intravenous fibrinolytic therapy, version 1.

Information model link: NHIM Physical wellbeing

Data set specifications:

	Start date	End date
DSS – Acute coronary syndrome (clinical)	04/06/2004	

Administrative attributes

Admin. status: CURRENT **Effective Date:** 04/06/2004

Source organisation: Acute Coronary Syndrome Data Working Group.

Source document:

Registration authority: National Health Information Group.

Steward: The National Heart Foundation of Australia.
 The Cardiac Society of Australia and New Zealand.

Comments:

Fibrinolytic therapy status

Identifying and definitional attributes

Knowledgebase ID:	001040	Version number:	1
Metadata type:	Data element		

Definition:	Identifies the person's fibrinolytic therapy status.
Context:	Health care and clinical settings.

Relational and representational attributes

Data type:	Numeric	Maximum field size:	4
Representational class:	Code	Format:	N(.NN)

Data domain:	10	Given
	21	Not given – therapy not indicated
	22	Not given – patient refusal
	23	Not given – previous haemorrhagic stroke at any time; other strokes or cerebrovascular events within 1 year
	24	Not given – known intracranial neoplasm
	25	Not given – active or recent (within 2 to 4 weeks) internal bleeding (does not include menses)
	26	Not given – suspected aortic dissection
	27	Not given – severe uncontrolled hypertension on presentation (blood pressure >180 mmHg systolic and/or 110 mmHg diastolic). Note: This could be an absolute contraindication in low-risk patients with MI.
	28	Not given – history of prior cerebrovascular accident or known intracerebral pathology not covered in 2.3 and 2.4 contraindications
	29	Not given – current use of anticoagulants in therapeutic doses (INR greater than or equal to 2); known bleeding diathesis
	30	Not given – recent trauma (within 2 to 4 weeks), including head trauma, traumatic or prolonged (greater than 10 minutes) CPR, or major surgery (less than 3 weeks)
	31	Not given – pregnancy
	32	Not given – other
	90	Not stated/inadequately described

Guide for use: More than one code may be recorded for the following codes: 23, 24, 25, 26, 27, 28, 29, 30 and 31.

For Acute coronary syndrome (ACS) reporting, to be collected with the data elements Date of triage, Time of triage and Acute coronary syndrome stratum. This data element pertains to the administering of fibrinolytic therapy drugs at any time point during this current event.

Verification rules:

Collection methods:

Related metadata: Is used in conjunction with Acute coronary syndrome procedure type, version 1
 Is used in conjunction with Date of triage, version 1
 Is used in conjunction with Time of triage, version 1
 Is used in conjunction with Time of intravenous fibrinolytic therapy, version 1
 Is used in conjunction with Date of intravenous fibrinolytic therapy, version 1
 Is used in conjunction with the data element Clinical procedure timing status, version 1

Information model: NHIM Physical wellbeing

Data set specifications:	Start date	End date
DSS – Acute coronary syndrome (clinical)	04/06/2004	

Administrative attributes

Admin. status: CURRENT **Effective Date:** 04/06/2004

Registration authority: National Health Information Group.

Steward: The National Heart Foundation of Australia.
 The Cardiac Society of Australia and New Zealand.

Source organisation: Acute Coronary Syndrome Data Working Group.

Source document:

Comments:

Floor/level number

Identifying and definitional attributes

Knowledgebase ID: 001010 **Version number:** 1
Metadata type: Data element

Definition:	Descriptor used to identify the floor or level of a multi-storey building/complex.
Context:	Australian addresses.

Relational and representational attributes

Data type: Alphanumeric **Maximum field size:** 4
Representational class: Text **Format:** AN(4)

Data domain:	Floor/level number (optional) and alphabetic suffix (optional).
---------------------	---

Guide for use: The Floor/level number must be recorded with its corresponding Floor/level type.
Some Floor/level numbers may be followed by an alphabetic suffix.
Examples of Floor/level identification:
FL 1A
L 3
LG A

Verification rules:

Collection methods: Do not leave a space between the number and alpha suffix.
To be collected in conjunction with Floor/level type.

Related metadata: Relates to the data element Floor/level type, version 1.
Is a composite part of the data element Address line, version 1.

Information model link: NHIM Address element

Data set specifications: **Start date** **End date**

Administrative attributes

Admin. status: CURRENT **Effective Date:** 25/02/2004

Source organisation: Health Data Standards Committee.

Source document: Australia Post Address Presentation Standard.

Registration authority: National Health Information Group.

Steward: Health Data Standards Committee.

Comments:

Floor/level type

Identifying and definitional attributes

Knowledgebase ID: 001011 **Version number:** 1
Metadata type: Data element

Definition: Descriptor used to classify the type of floor or level of a multi-storey building/complex.

Context: Australian addresses.

Relational and representational attributes

Data type: Alphabetic **Maximum field size:** 2
Representational class: Code **Format:** A(2)

Data domain:	B	Basement
	FL	Floor
	G	Ground
	L	Level
	LG	Lower ground
	M	Mezzanine
	UG	Upper ground

Guide for use: Some floor/level identification may require the Floor/level type plus a Floor/level number to be recorded.

Verification rules:

Collection methods: To be collected in conjunction with Floor/level number where applicable. Some Floor/level type entries will often have no corresponding number, e.g. Basement, Ground, Lower ground, Mezzanine and Upper ground.

Related metadata: Relates to the data element Floor/level number, version 1.
 Is a composite part of the data element Address line, version 1.

Information model link: NHIM Address element

Data set specifications: **Start date** **End date**

Administrative attributes

Admin. status: CURRENT **Effective Date:** 25/02/2004

Source organisation: Health Data Standards Committee.

Source document: Australia Post Address Presentation Standard.

Registration authority: National Health Information Group.

Steward: Health Data Standards Committee.

Comments:

Functional stress test element

Identifying and definitional attributes

Knowledgebase ID: 001041 **Version number:** 1
Metadata type: Data element

Definition: Identifies the element included in an electrocardiogram stress test.
Context: Health care and clinical settings.

Relational and representational attributes

Data type: Numeric **Maximum field size:** 1
Representational class: Code **Format:** N

Data domain:

1	ECG monitoring
2	Echocardiography
3	Radionuclide (perfusion) imaging (e.g. Thallium, Sestamibi)
9	Not stated/inadequately described

Guide for use: More than one code may be recorded (code 9 is excluded from multiple coding).

Verification rules:

Collection methods:

Related metadata: is a qualifier of Functional stress test ischaemic result, version 1

Information model: NHIM Service provision event

Data set specifications:

	Start date	End date
DSS – Acute coronary syndrome (clinical)	04/06/2004	

Administrative attributes

Admin. status: CURRENT **Effective Date:** 04/06/2004

Source organisation: Acute Coronary Syndrome Data Working Group.

Source document:

Registration authority: National Health Information Group.

Steward: The National Heart Foundation of Australia.
The Cardiac Society of Australia and New Zealand.

Comments:

Functional stress test ischaemic result

Identifying and definitional attributes

Knowledgebase ID:	001041	Version number:	1
Metadata type:	Data element		

Definition: Indicates the result of the person's electrocardiogram stress in terms of ischaemic outcome.

Context: Health care and clinical settings.

Relational and representational attributes

Representational class:	Code	Format:	N
Data type:	Numeric	Maximum field size:	1

Data domain:	1	Not done
	2	Positive
	3	Negative
	4	Equivocal
	9	Not stated/inadequately described

Guide for use: For Acute coronary syndrome (ACS) reporting, can be used to determine diagnostic strata.

Code 2. Positive:

On an exercise tolerance test, the patient developed either:

- a. Both ischaemic discomfort and ST shift greater than or equal to 1 mm (0.1 mV) (horizontal or downsloping) or
- b. New ST shift greater than or equal to 2 mm (0.2 mV) (horizontal or down-sloping) believed to represent ischaemia even in the absence of ischaemic discomfort.

On cardiac imaging investigation (e.g. exercise thallium or MIBI test, stress echocardiography, or dipyridamole, thallium, or adenosine radioisotope scan)

- a. Evidence of reversible ischaemia on nuclear imaging of the myocardium
- b. Evidence of inducible ischaemic response during echocardiographic imaging of the myocardium

If the patient had an equivalent type of exercise test) but a definite evidence of ischaemia on cardiac imaging (e.g. an area of clear reversible ischaemia), this should be considered a positive test.

Code 3. Negative: No evidence of ischaemia (i.e., no typical angina pain and no ST shifts).

Code 4. Equivocal: Either

- a. Typical ischaemic pain but no ST shift greater than or equal to 1 mm (0.1 mV) (horizontal or downsloping) or ST shift of 1 mm (0.1 mV) (horizontal or downsloping) but no ischaemic discomfort.
- b. Defect on myocardial imaging of uncertain nature or significance.

Verification rules:

Collection methods: May be collected as part of Acute coronary syndrome (ACS) reporting.

Related metadata: is a qualifier of Acute coronary syndrome stratum, version 1
is qualified by Functional stress test elements, version 1
is used in conjunction with the data element Clinical procedure timing status, version 1

Information model: NHIM Physical wellbeing

Data set specifications:	Start date	End date
DSS – Acute coronary syndrome (clinical)	04/06/2004	

Administrative attributes

Admin. status: CURRENT **Effective Date:** 04/06/2004

Source organisation: Acute Coronary Syndrome Data Working Group.

Source document:

Registration authority: National Health Information Group.

Steward: The National Heart Foundation of Australia.
The Cardiac Society of Australia and New Zealand.

Comments:

Glycoprotein IIb/IIIa receptor antagonist status

Identifying and definitional attributes

Knowledgebase ID: 001042 **Version number:** 1
Metadata type: Data element

Definition: Identifies the person's glycoprotein IIb/IIIa receptor antagonist therapy status.

Context: Health care and clinical settings.

Relational and representational attributes

Data type: Numeric **Maximum field size:** 3
Representational class: Code **Format:** N(.N)

Data domain:	10	Given
	21	Not given – therapy not indicated
	22	Not given – patient refusal
	23	Not given – known intracranial neoplasm
	24	Not given – active or recent (within 2 to 4 weeks) internal bleeding (does not include menses). Suspected aortic dissection
	25	Not given – history of prior cerebrovascular accident or known intracerebral pathology not covered in contraindications
	26	Not given – recent trauma (within 2 to 4 weeks), including head trauma, traumatic or prolonged (greater than 10 minutes) CPR, or major surgery (less than 3 weeks)
	27	Not given – pregnancy
	28	Not given – other
	90	Not stated/inadequately described

Guide for use: If recording 'Not given', record the principal reason if more than one code applies.

This data element pertains to the administering of Glycoprotein IIb/IIIa receptor antagonist drugs at any time point during this current event.

Verification rules:

Collection methods:

Related metadata:

Information model: NHIM Physical wellbeing

Data set specifications: **Start date** **End date**
DSS – Acute coronary syndrome (clinical) 04/06/2004

Administrative attributes

<i>Admin. status:</i>	CURRENT	<i>Effective Date:</i>	04/06/2004
<i>Registration authority:</i>	National Health Information Group.		
<i>Steward:</i>	The National Heart Foundation of Australia. The Cardiac Society of Australia and New Zealand.		
<i>Source organisation:</i>	Acute Coronary Syndrome Data Working Group.		
<i>Source document:</i>			
<i>Comments:</i>			

Heart rate

Identifying and definitional attributes

Knowledgebase ID: 001043 **Version number:** 1
Metadata type: Data element

Definition: The person's heart rate in beats per minute.
Context: Health care and clinical settings.

Relational and representational attributes

Data type: Numeric **Maximum field size:** 3
Representational class: Quantitative value **Format:** NNN

Data domain:

997	Cardiac arrest
998	Not recorded
999	Not stated/inadequately described

Guide for use: Measurement expressed in beats per minute.

Verification rules:

Collection methods: For Acute coronary syndrome (ACS) reporting, collected at time of presentation. If heart rate is not recorded at the exact time of presentation, record the first heart rate measured closest to the time of presentation.

Related metadata: is used in conjunction with Time patient presents, version 2
 is used in conjunction with Heart rhythm type, version 1

Information model: NHIM Service provision event

Data set specifications:	Start date	End date
DSS – Acute coronary syndrome (clinical)	04/06/2004	

Administrative attributes

Admin. status: CURRENT **Effective Date:** 04/06/2004

Source organisation: Acute Coronary Syndrome Data Working Group.

Source document:

Registration authority: National Health Information Group.

Steward: The National Heart Foundation of Australia.
 The Cardiac Society of Australia and New Zealand.

Comments:

Heart rhythm type

Identifying and definitional attributes

Knowledgebase ID: 001044 **Version number:** 1
Metadata type: Data element

Definition: The type of rhythm associated with the beating of the heart as determined from the electrocardiogram (ECG).

Context: Health care and clinical settings.

Relational and representational attributes

Data type: Numeric **Maximum field size:** 2
Representational class: Code **Format:** N(N)

Data domain:	1	Sinus rhythm
	2	Atrial fibrillation
	3	Atrial flutter
	4	Second degree heart block
	5	Complete heart block
	6	Supraventricular tachycardia
	7	Idioventricular rhythm
	8	Ventricular tachycardia
	9	Ventricular fibrillation
	10	Paced
	11	Other rhythm
	99	Not stated/inadequately described

Guide for use: For Acute coronary syndrome (ACS) reporting, the ECG used for assessment on presentation.

Collection methods:

Related metadata: Is a qualifier of Reason for readmission – acute coronary syndrome, version 1
 Is used in conjunction with Date of triage, version 1
 Is used in conjunction with Time of triage, version 1
 Is used in conjunction with Heart rate, version 1
 Is used in conjunction with the data element Acute coronary syndrome procedure type, version 1
 Is used in conjunction with the data element Electrocardiogram (ECG) change – type, version 1

Information model: NHIM Physical wellbeing

Data set specifications: **Start date** **End date**
 DSS – Acute coronary syndrome (clinical) 04/06/2004

Administrative attributes

Admin. status: CURRENT *Effective Date:* 04/06/2004

Source organisation: Acute Coronary Syndrome Data Working Group.

Source document:

Registration authority: National Health Information Group.

Steward: The National Heart Foundation of Australia.
The Cardiac Society of Australia and New Zealand.

Comments:

Histopathological grade

Identifying and definitional attributes

Knowledgebase ID: 001066 **Version number:** 1
Metadata type: Data element

Definition: The histopathological grade, differentiation or phenotype describes how little the tumour resembles the normal tissue from which it arose.

Context:

Relational and representational attributes

Data type: Numeric **Maximum field size:** 1
Representational class: Code **Format:** N

Data domain: The sixth digit of the ICD-O morphology code

1	Grade 1:	Well differentiated, differentiated, NOS
2	Grade 2:	Moderately differentiated, moderately well differentiated, intermediate differentiation
3	Grade 3:	Poorly differentiated
4	Grade 4:	Undifferentiated, anaplastic
Lymphomas and leukaemias		
5	T-cell:	T-cell
6	B-cell:	B-cell, Pre-B, B-Precursor
8	NK:	Natural killer cell
Unknown or not stated		
9	Grade/differentiation unknown:	Grade/cell type not determined, not stated or not applicable

Guide for use: Only one code can be recorded.

Verification rules:

Collection methods:

Related metadata: Relates to the data element Morphology of cancer, version 1.
 Relates to the data element Date of diagnosis of cancer, version 1.
 Relates to the data element Primary site of cancer, version 1.

Information model link: NHIM Assessment event

Data set specifications: **Start date** **End date**
 DSS – Cancer (clinical) 04/06/2004

Administrative attributes

Admin. status: CURRENT **Effective Date:** 04/06/2004

Source organisation: World Health Organization.
Commission on Cancer, American College of Surgeons.

Source document: World Health Organization, *International Classification of Diseases Oncology*, Third edition (ICD-O-3) (2000).
Commission on Cancer, *Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II* (1998).

Registration authority: National Health Information Group.

Steward:

Comments:

House/property number

Identifying and definitional attributes

Knowledgebase ID: 001012 **Version number:** 1
Metadata type: Data element

Definition: The numeric or alphanumeric reference number of a house or property that is unique within a street name.

Context: Australian addresses.

Relational and representational attributes

Data type: Alphanumeric **Maximum field size:** 12
Representational class: Text **Format:** AN(12)

Data domain: Valid alphanumeric characters.

Guide for use: Generally, only one house/property number is used. However, if the house/property number includes a number range, the range of applicable numbers should be included, separated by a hyphen (-), with no spaces between numerals, i.e. 17-19

- House/property number 1 – refers to physical House/property number and for ranges is the starting number (five numeric characters)
- House/property number Suffix 1 – a single character identifying the House/property number suffix (one alphanumeric character)
- House/property number 2 – refers to a physical House/property number and for ranges is the finishing number (five numeric characters)
- House/property number suffix 2 – a single character identifying the House/property number suffix (one alphanumeric character) with no space between the numeric and the alpha characters.

For example; '401A 403B'

'401' is House/property number first in range

'A' is the House/Property suffix 1

'403' is House/property number last in range

'B' is House/Property suffix 2

Verification rules:

Collection methods:

Related metadata: Is a composite part of the data element Address line, version 1.

Information model link: NHIM Address element

Data set specifications: **Start date** **End date**

Administrative attributes

<i>Admin. status:</i>	CURRENT	<i>Effective Date:</i>	25/02/2004
<i>Source organisation:</i>	Health Data Standards Committee.		
<i>Source document:</i>	Australia Post Address Presentation Standard.		
<i>Registration authority:</i>	National Health Information Group.		
<i>Steward:</i>	Health Data Standards Committee.		
<i>Comments:</i>			

Initial treatment episode for cancer

Identifying and definitional attributes

Knowledgebase ID: 001067 **Version number:** 1
Metadata type: Data element concept

Definition:	The initial course of cancer directed treatment or treatments, with defined dates of commencement and cessation, given to the patient by a treatment provider or team of providers. It includes all treatments administered to the patient before disease progression or recurrence and applies to surgical treatment, radiation therapy and systemic agent therapy for cancer.
Context:	This concept is required to provide the basis for a standard approach to recording and monitoring patterns of initial treatment for cancer patients.

Relational and representational attributes

Data type: **Maximum field size:**
Representational class: **Format:**

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related metadata:

- Relates to the data element Intention of treatment for cancer, version 1.
- Relates to the data element Cancer treatment – target site, version 1.
- Relates to the data element Cancer treatment type, version 1.
- Relates to the data element Surgical treatment procedure for cancer, version 1.
- Relates to the data element Radiotherapy treatment given, version 1.
- Relates to the data element Received radiation dose, version 1.
- Relates to the data element Systemic therapy agent name, version 1.
- Relates to the data element Date of surgical treatment for cancer, version 1.
- Relates to the data element Cancer initial treatment – starting date, version 1.
- Relates to the data element Cancer initial treatment – completion date, version 1.

Information model link: NHIM Request for/entry into service event

Administrative attributes

<i>Admin. status:</i>	CURRENT	<i>Effective Date:</i>	04/06/2004
<i>Source organisation:</i>	Commission on Cancer, American College of Surgeons.		
<i>Source document:</i>	Commission on Cancer, <i>Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II</i> (1998). Commission on Cancer, <i>Facility Oncology Registry Data Standards</i> (2002).		
<i>Registration authority:</i>	National Health Information Group.		
<i>Steward:</i>			
<i>Comments:</i>			

Intention of treatment for cancer

Identifying and definitional attributes

Knowledgebase ID: 001068 **Version number:** 1
Metadata type: Data element

Definition:	The intention of the initial treatment for cancer for the particular patient.
Context:	This item is collected for surgical treatment, radiation therapy and systemic therapy agent treatment. It is used for correlating outcome with original intent of the treatment.

Relational and representational attributes

Data type: Alphanumeric **Maximum field size:** 1
Representational class: Code **Format:** N

Data domain:	0	Did not have treatment
	1	Prophylactic
	2	Curative
	3	Non-curative or palliative
	9	Not stated.

Guide for use:

Code 0	Did not have treatment, is used when the patient did not have treatment as part of the initial management plan.
Code 1	Prophylactic, is used when the cancer has not developed.
Code 2	Curative, is used when treatment is given for control of the disease.
Code 3	Non-curative or palliative, is used when the cure is unlikely to be achieved and treatment is given primarily for the purpose of pain control. Other benefits of the treatment are considered secondary contributions to the patient's quality of life.
Code 9	Intention was not stated. Patient had treatment for cancer but the intention was not stated.

Verification rules:

Collection methods:

Related metadata:

- Relates to the data element Cancer treatment type, version 1.
- Relates to the data element concept Initial treatment episode for cancer, version 1.
- Relates to the data element Surgical treatment procedure for cancer, version 1.
- Relates to the data element Radiotherapy treatment given, version 1.

Information model link: NHIM Exit/leave from service event

Data set specifications:	Start date	End date
DSS – Cancer (clinical)	04/06/2004	

Administrative attributes

Admin. status:	CURRENT	Effective Date:	04/06/2004
-----------------------	---------	------------------------	------------

Source organisation:	Commission on Cancer, American College of Surgeons. New South Wales Health Department.
-----------------------------	---

Source document:	Commission on Cancer, <i>Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II</i> (1998). Public Health Division NSW <i>Clinical Cancer Data Collection for Outcomes and Quality. Data Dictionary Version 1</i> Sydney NSW Health Dept (2001).
-------------------------	---

Registration authority:	National Health Information Group.
--------------------------------	------------------------------------

Steward:

Comments:

Killip classification code

Identifying and definitional attributes

Knowledgebase ID:	001045	Version number:	1
Metadata type:	Data element		

Definition: Identifies the Killip class, as a measure of haemodynamic compromise, of the person at the time of presentation.

Context: Health care and clinical settings.

Relational and representational attributes

Data type:	Numeric	Maximum field size:	1
Representational class:	Code	Format:	N

Data domain:	1	Class 1
	2	Class 2
	3	Class 3
	4	Class 4
	8	Other
	9	Not stated/inadequately described

Guide for use:

Code 1 Absence of crepitations/rales over the lung fields and absence of S3.

Code 2 Crepitations/rales over 50% or less of the lung fields or the presence of an S3.

Code 3 Crepitations/rales over more than 50% of the lung fields.

Code 4 Cardiogenic Shock. Clinical criteria for cardiogenic shock are hypotension (a systolic blood pressure of less than 90 mmHg for at least 30 minutes or the need for supportive measures to maintain a systolic blood pressure of greater than or equal to 90 mmHg), end-organ hypoperfusion (cool extremities or a urine output of less than 30 ml/h, and a heart rate of greater than or equal to 60 beats per minute). The haemodynamic criteria are a cardiac index of no more than 2.2 l/min per square meter of body-surface area and a pulmonary-capillary wedge pressure of at least 15 mmHg.

For Acute coronary syndrome (ACS) reporting, to be determined at the time of presentation. The data element describes the objective evidence of haemodynamic compromise by clinical examination at the time of presentation. Rales or crepitations represent evidence of pulmonary interstitial oedema on lung auscultation and an S3 is an audible extra heart sound by cardiac auscultation.

Verification rules:

Collection methods: For Acute coronary syndrome (ACS) reporting, Killip classification at the time of presentation.

Related metadata: Is a qualifier of Acute coronary syndrome stratum, version 1

Information model: NHIM Physical wellbeing

<i>Data set specifications:</i>	<i>Start date</i>	<i>End date</i>
DSS – Acute coronary syndrome (clinical)	04/06/2004	

Administrative attributes

Admin. status: CURRENT *Effective Date:* 04/06/2004

Source organisation: Acute Coronary Syndrome Data Working Group.

Source document:

Registration authority: National Health Information Group.

Steward: The National Heart Foundation of Australia.
The Cardiac Society of Australia and New Zealand.

Comments: