# Leave days from residential care

## Identifying and definitional attributes

| | | | |
|---|---|---|---|
| ***Knowledgebase ID:*** | ***001005*** | ***Version number:*** | ***1*** |
| ***Metadata type:*** | Data element | | |

| | |
|---|---|
| ***Definition:*** | The number of days spent on leave from a residential care service during an episode of residential care. |
| ***Context:*** | Specialised mental health services (Residential mental health care). |

## Relational and representational attributes

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

| | |
|---|---|
| ***Data domain:*** | Count in number of days. |

***Guide for use:***

A day is measured from midnight to midnight.

Leave days can occur for a variety of reasons, including:

- treatment by specialised mental health service
- treatment by a non-specialised health service
- time in the community

The following rules apply in the calculation of leave days:

- the day the resident goes on leave is counted as a leave day
- days the resident is on leave is counted as leave days
- the day the resident returns from leave is not counted as a leave day
- if the resident starts a residential stay and goes on leave on the same day, this is not counted as a leave day
- if the resident returns from leave and then goes on leave again on the same day, this is counted as a leave day
- if the resident returns from leave and ends residential care on the same day, the day should not be counted as leave day
- leave days at the end of a residential stay after the commencement of leave are not counted.

If a period of leave is greater than seven days or the resident fails to return from leave, then the residential stay is formally ended.

***Verification rules:***

Episode of residential care end date minus episode of residential care start date minus leave days from residential care must be greater than or equal to zero days.

***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 Episode of residential care, version 1.

Relates to the data element concept Resident, version 1.

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

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

Relates to the data element Residential stay start date, 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:***

# Lipid-lowering therapy status

## Identifying and definitional attributes

| | | | |
|---|---|---|---|
| ***Knowledgebase ID:*** | ***001046*** | ***Version number:*** | ***1*** |
| ***Metadata type:*** | Data element | | |

| | |
|---|---|
| ***Definition:*** | Identifies the person's lipid lowering therapy status. |
| ***Context:*** | Health care and clinical settings. |

## Relational and representational attributes

| | | | |
|---|---|---|---|
| ***Data type:*** | Numeric | ***Maximum field size:*** | 2 |
| ***Representational class:*** | Code | ***Format:*** | NN |

***Data domain:***

| | |
|---|---|
| 10 | Given |
| 21 | Not given—patient refusal |
| 22 | Not given—true allergy to lipid lowering therapy |
| 23 | Not given—previous myopathy |
| 24 | Not given—hepatic dysfunction |
| 25 | 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.

***Verification rules:***

***Collection methods:*** For Acute coronary syndrome (ACS) reporting, can be collected at any time point during the management of the current event (i.e. at the time of triage, at times during the admission, or at the time of discharge).

***Related metadata:***

***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.

***Source organisation:*** Acute Coronary Syndrome Data Working Group.

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

***Comments:***

# Lot/section number

## Identifying and definitional attributes

| | | | |
|---|---|---|---|
| ***Knowledgebase ID:*** | ***001013*** | ***Version number:*** | ***1*** |
| ***Metadata type:*** | Data element | | |

| | |
|---|---|
| ***Definition:*** | The lot/section reference allocated to an address in the absence of street numbering. |
| ***Context:*** | Australian addresses. |

## Relational and representational attributes

| | | | |
|---|---|---|---|
| ***Data type:*** | Alphanumeric | ***Maximum field size:*** | 15 |
| ***Representational class:*** | Text | ***Format:*** | AN(15) |

| | |
|---|---|
| ***Data domain:*** | Valid alphanumeric characters. |

***Guide for use:***

This standard is suitable for postal purposes as well as the physical identification of addresses.

A lot number shall be used only when a street number has not been specifically allocated or is not readily identifiable with the property.

For identification purposes, the word 'Lot' or 'Section' should precede the lot number and be separated by a space.

Examples are as follows:

Section 123456

Lot 716

Lot 534A

Lot 17 Jones Street

***Verification rules:***

***Collection methods:*** The Lot/section number is positioned before the Street name and type, located in the same line containing the Street name.

***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

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

***Source organisation:*** Health Data Standards Committee.

***Source document:*** AS4590 Interchange of client information.

Australia Post Address Presentation Standard.

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

***Steward:*** Health Data Standards Committee.

***Comments:*** Lot/section numbers are generally used only until an area has been developed.

# Most valid basis of diagnosis of cancer

## Identifying and definitional attributes

| | | | |
|---|---|---|---|
| *Knowledgebase ID:* | *000861* | *Version number:* | *1* |
| *Metadata type:* | Data element | | |

| | |
|---|---|
| *Definition:* | The basis of diagnosis of a cancer is the microscopic or non-microscopic or death certificate source of the diagnosis. The most valid basis of diagnosis is that accepted by the cancer registry as the most reliable diagnostic source of the death certificate, non-microscopic, and microscopic sources available. |
| *Context:* | Knowledge of the basis of a diagnosis underlying a cancer code is one of the most important aids in assessing the reliability of cancer statistics. |

## Relational and representational attributes

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

*Data domain:*

0 Death Certificate Only: Information provided is from a death certificate.

Non-microscopic

1 Clinical: Diagnosis made before death, but without any of the following (codes 2–7).

2 Clinical investigation: All diagnostic techniques, including x-ray, endoscopy, imaging, ultrasound, exploratory surgery (e.g. laparotomy), and autopsy, without a tissue diagnosis.

3 Specific tumour markers: Including biochemical and/or immunological markers that are specific for a tumour site.

Microscopic

4 Cytology: Examination of cells from a primary or secondary site, including fluids aspirated by endoscopy or needle; also includes the microscopic examination of peripheral blood and bone marrow aspirates.

5 Histology of metastasis: Histological examination of tissue from a metastasis, including autopsy specimens.

6 Histology of a primary tumour: Histological examination of tissue from primary tumour, however obtained, including all cutting techniques and bone marrow biopsies; also includes autopsy specimens of primary tumour.

7 Histology: either unknown whether of primary or metastatic site, or not otherwise specified.

Other

9 Unknown.

*Guide for use:* The most valid basis of diagnosis may be the initial histological examination of the primary site, or it may be the post-mortem examination (sometimes corrected even at this point when histological results become available). In a cancer registry setting, this item should be

revised if later information allows its upgrading.

When considering the most valid basis of diagnosis, the minimum requirement of a cancer registry is differentiation between neoplasms that are verified microscopically and those that are not. To exclude the latter group means losing valuable information; the making of a morphological (histological) diagnosis is dependent upon a variety of factors, such as age, accessibility of the tumour, availability of medical services, and, last but not least, upon the beliefs of the patient.

A biopsy of the primary tumour should be distinguished from a biopsy of a metastasis, e.g. at laparotomy; a biopsy of cancer of the head of the pancreas versus a biopsy of a metastasis in the mesentery. However, when insufficient information is available, Code 8 should be used for any histological diagnosis. Cytological and histological diagnoses should be distinguished.

Morphological confirmation of the clinical diagnosis of malignancy depends on the successful removal of a piece of tissue that is cancerous. Especially when using endoscopic procedures (bronchoscopy, gastroscopy, laparoscopy, etc.), the clinician may miss the tumour with the biopsy forceps. These cases must be registered on the basis of endoscopic diagnosis and not excluded through lack of a morphological diagnosis.

Care must be taken in the interpretation and subsequent coding of autopsy findings, which may vary as follows:

a) the post-mortem report includes the post-mortem histological diagnosis (in which case, one of the Histology codes should be recorded instead);

b) the autopsy is macroscopic only, histological investigations having been carried out only during life (in which case, one of the Histology codes should be recorded instead);

c) the autopsy findings are not supported by any histological diagnosis.

***Verification rules:***

***Collection methods:***

***Related metadata:***

***Information model link:*** NHIM Physical wellbeing

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

## Administrative attributes

***Admin. status:*** CURRENT ***Effective Date:*** 25/02/04

***Source organisation:*** International Agency for Research on Cancer and International Association of Cancer Registries.

***Source document:***

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

***Steward:***

***Comments:*** In a hospital setting this item should be collected on the most valid basis of diagnosis at this admission. If more than one diagnostic technique is used during an admission, select the higher code from 1 to 8.

# Oestrogen receptor assay status

## Identifying and definitional attributes

| | | | |
|---|---|---|---|
| ***Knowledgebase ID:*** | ***001069*** | ***Version number:*** | ***1*** |
| ***Metadata type:*** | Data element | | |

| | |
|---|---|
| ***Definition:*** | The results of oestrogen receptor assay at the time of diagnosis of the primary breast tumour. |
| ***Context:*** | Collected for breast cancers. Hormone receptor status is an important prognostic indicator for breast cancer. |

## Relational and representational attributes

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

***Data domain:***

| | |
|---|---|
| 0 | Test not done (test not ordered or not performed) |
| 1 | Test done, results positive (oestrogen receptor positive) |
| 2 | Test done, results negative (oestrogen receptor negative) |
| 8 | Test done but results unknown |

***Guide for use:*** The Australian Cancer Network Working Party established to develop guidelines for the pathology reporting of breast cancer recommends that hormone receptor assays be performed on all cases of invasive breast carcinoma. The report should include

- the percentage of nuclei staining positive and the predominant staining intensity (low, medium, high) and
- a conclusion as to whether the assay is positive or negative

***Verification rules:***

***Collection methods:***

***Related metadata:***

***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:***

Royal College of Pathologists of Australasia

Australian Cancer Network

Commission on Cancer, American College of Surgeons

***Source document:*** Royal College of Pathologists of *Australasia Manual of Use and Interpretation of Pathology Tests*: Third Edition Sydney (2001)

Australian Cancer Network Working Party *The pathology reporting of breast cancer. A guide for pathologists, surgeons and radiologists* Second Edition Sydney (2001)

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:***

# Outcome of initial treatment

## Identifying and definitional attributes

***Knowledgebase ID:*** ***001071*** ***Version number:*** ***1***

***Metadata type:*** Data element

| | |
|---|---|
| ***Definition:*** | The outcome of initial treatment describes the response of the tumour at the completion of the initial treatment modalities. |
| ***Context:*** | This item is collected for assessing disease status at the end of primary treatment. |

## Relational and representational attributes

| | | | |
|---|---|---|---|
| ***Data type:*** | Numeric | ***Maximum field size:*** | 3 |
| ***Representational class:*** | Code | ***Format:*** | N.N |

***Data domain:***

1.0 Complete response

2.0 Incomplete response

- 2.1 Partial response
- 2.2 Stable or static disease
- 2.3 Progressive disease

9.0 Not assessed or unable to be assessed

***Guide for use:***

| | |
|---|---|
| Code 1.0 | Complete disappearance of all measurable disease, including tumour markers, for at least four weeks. No new lesions or new evidence of disease. |
| Code 2.1 | A decrease by at least 50% of the sum of the products of the maximum diameter and perpendicular diameter of all measurable lesions, for at least four weeks. No new lesions or worsening of disease. |
| Code 2.2 | No change in measurable lesions qualifying as partial response or progression and no evidence of new lesions. |
| Code 2.3 | An increase by at least 25% of the sum of the products of the maximum diameter and a perpendicular diameter of any measurable lesion, or the appearance of new lesions. |

***Verification rules:***

***Collection methods:***

***Related metadata:***

***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:*** NSW Health Department.

***Source document:*** Public Health Division *NSW Clinical Cancer Data Collection for Outcomes and Quality. Data Dictionary* Version 1 Sydney NSW Health Dept (2001).

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

***Steward:***

***Comments:***

# Postal delivery service number

## Identifying and definitional attributes

| | | | |
|---|---|---|---|
| ***Knowledgebase ID:*** | ***001018*** | ***Version number:*** | ***1*** |
| ***Metadata type:*** | Data element | | |

| | |
|---|---|
| ***Definition:*** | The specification of the identification of a postal delivery service such as General Post Office Box, Community Mail Bag, etc. to clearly distinguish it from another when applicable. |
| ***Context:*** | Australian addresses. |

## Relational and representational attributes

| | | | |
|---|---|---|---|
| ***Data type:*** | Alphanumeric | ***Maximum field size:*** | 11 |
| ***Representational class:*** | Text | ***Format:*** | AN(11) |

***Data domain:***

***Guide for use:*** The identification of a postal delivery service may be composed of a Prefix a Number and a Suffix as per the following format:

Prefix A(3)

Number N(5)

Suffix A(3)

The identification may also not be required for certain services.

Examples:

PO BOX *C96*

CARE PO

RMB *123*

GPO BOX *1777Q*

***Verification rules:***

***Collection methods:*** To be collected in conjunction with Postal delivery service type abbreviation.

***Related metadata:*** Relates to Postal delivery service type — abbreviation, version 1.

Relates to the data element Suburb/town/locality name, version 2.

Relates to the data element Australian state/territory identifier, version 4.

Relates to the data element Postcode — Australian, version 3.

***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:*** | AS4590 Interchange of client information. | | |
| ***Registration authority:*** | National Health Information Group. | | |
| ***Steward:*** | Health Data Standards Committee. | | |
| ***Comments:*** | | | |

# Postal delivery service type — abbreviation

## Identifying and definitional attributes

| | | | |
|---|---|---|---|
| ***Knowledgebase ID:*** | ***001017*** | ***Version number:*** | ***1*** |
| ***Metadata type:*** | Data element | | |

| | |
|---|---|
| ***Definition:*** | Abbreviation of the type of the postal delivery service. |
| ***Context:*** | Australian addresses. |

## Relational and representational attributes

| | | | |
|---|---|---|---|
| ***Data type:*** | Alphabetic | ***Maximum field size:*** | 11 |
| ***Representational class:*** | Text | ***Format:*** | A(11) |

***Data domain:***

| **Abbreviation** | **Postal Delivery Type** |
|---|---|
| CARE PO | Care-of Post Office (also known as Poste Restante) |
| CMA | Community Mail Agent |
| CMB | Community Mail Bag |
| GPO BOX | General Post Office Box |
| LOCKED BAG | Locked Mail Bag Service |
| MS | Mail Service |
| PO BOX | Post Office Box |
| PRIVATE BAG | Private Mail Bag Service |
| RSD | Roadside Delivery |
| RMB | Roadside Mail Box/Bag |
| RMS | Roadside Mail Service |

***Guide for use:***

***Verification rules:***

***Collection methods:*** To be collected in conjunction with Postal delivery service number when applicable.

***Related metadata:*** Relates to the data element Postal delivery service number, version 1.

Relates to the data element Suburb/town/locality name, version 2.

Relates to the data element Australian state/territory identifier, version 4.

Relates to the data element Postcode — Australian, version 3.

***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:*** | AS4590 Interchange of client information. | | |
| ***Registration authority:*** | National Health Information Group. | | |
| ***Steward:*** | Health Data Standards Committee. | | |
| ***Comments:*** | | | |

# Progesterone receptor assay status

## Identifying and definitional attributes

| | | | |
|---|---|---|---|
| ***Knowledgebase ID:*** | ***001072*** | ***Version number:*** | ***1*** |
| ***Metadata type:*** | Data element | | |

| | |
|---|---|
| ***Definition:*** | The results of progesterone receptor assay at the time of diagnosis of the primary breast tumour. |
| ***Context:*** | Collected for breast cancers. Hormone receptor status is an important prognostic indicator for breast cancer. |

## Relational and representational attributes

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

| | | |
|---|---|---|
| ***Data domain:*** | 0 | Test not done (test not ordered or not performed) |
| | 1 | Test done, results positive (progesterone receptor positive) |
| | 2 | Test done, results negative (Progesterone receptor negative) |
| | 8 | Test done but results unknown |
| | 9 | Unknown |

***Guide for use:*** The Australian Cancer Network Working Party established to develop guidelines for the pathology reporting of breast cancer recommends that hormone receptor assays be performed on all cases of invasive breast carcinoma. The report should include:

- the percentage of nuclei staining positive and the predominant staining intensity (low, medium, high) and
- a conclusion as to whether the assay is positive or negatice

***Verification rules:***

***Collection methods:***

***Related metadata:***

***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:***

Royal College of Pathologists of Australasia.

Australian Cancer Network.

Commission on Cancer, American College of Surgeons.

***Source document:***

Royal College of Pathologists of Australasia *Manual of Use and Interpretation of Pathology Tests*: Third Edition *Sydney (2001).*

Australian Cancer Network Working Party *The pathology reporting of breast cancer. A guide for pathologists, surgeons and radiologists* Second Edition *Sydney (2001).*

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:***

# Radiotherapy treatment type

## Identifying and definitional attributes

***Knowledgebase ID:*** ***001073*** ***Version number:*** ***1***

***Metadata type:*** Data element

***Definition:*** The type of radiation therapy used in initial treatment of the cancer.

***Context:*** This item is collected for the analysis of outcome by treatment type.

## Relational and representational attributes

***Data type:*** Numeric ***Maximum field size:*** 1

***Representational class:*** Code ***Format:*** N

***Data domain:***

| Code | Description |
| --- | --- |
| 0 | No radiotherapy treatment given |
| 1 | External beam radiation |
| 2 | Brachytherapy (radioactive implants) |
| 3 | Unsealed radioisotopes |
| 9 | Radiotherapy was administered but method was not stated |

***Guide for use:*** Code 2 Brachytherapy (radioactive implants) is likely to be listed as a procedure for admitted patients. Most external beam radiotherapy is delivered on an outpatient basis.

***Verification rules:*** If codes 1, 2, 3 or 9 are used, Received radiation dose should also be collected.

***Collection methods:***

***Related metadata:*** Relates to the data element concept Initial treatment episode 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.

Relates to the data element Received radiation dose, 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.

NSW Health Department.

| | |
|---|---|
| ***Source document:*** | Commission on Cancer, *Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS)* Volume II (1998).<br>Public Health Division *NSW Clinical Cancer Data Collection for Outcomes and Quality. Data Dictionary* Version 1 Sydney NSW Health Dept (2001). |
| ***Registration authority:*** | National Health Information Group. |
| ***Steward:*** | |
| ***Comments:*** | |

# Reason for readmission—Acute coronary syndrome

## Identifying and definitional attributes

| | | | |
|---|---|---|---|
| *Knowledgebase ID:* | ***001047*** | *Version number:* | ***1*** |
| *Metadata type:* | Data element | | |

| | |
|---|---|
| *Definition:* | Identifies the main reason for the admission, to any hospital, of a person within 28 days of discharge from an episode of admitted patient care for acute coronary syndrome. |
| *Context:* | Acute coronary syndrome reporting only. |

## Relational and representational attributes

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

*Data domain:*

Acute coronary syndrome:

| | |
|---|---|
| 1 | ST elevation myocardial infarction |
| 2 | non-ST elevation ACS with high-risk features |
| 3 | non-ST elevation ACS with intermediate-risk features |
| 4 | non-ST elevation ACS with low-risk features |
| 5 | Planned Percutaneous Coronary Intervention (PCI) |
| 6 | Planned Coronary Artery Bypass Grafting (CABG) |
| 7 | Heart Failure (without MI) |
| 8 | Arrhythmia (without MI) |
| 9 | Conduction disturbance (without MI) |
| 88 | Non-cardiac cause |
| 99 | Not stated/inadequately described |

*Guide for use:*

This data element is designed to identify recurrent admissions following an initial presentation with ACS, not necessarily to the hospital responsible for the index admission. The reason for readmission may be for cardiac or non-cardiac related causes.

Code 5 is coded when a readmission and PCI is planned, i.e. not precipitated by a recurrent ischaemic event. If a recurrent ischaemic event precipitates a readmission with an associated PCI undertaken, one of codes 1–4 should be coded.

Code 6 is coded when a readmission and CABG is planned, i.e. not precipitated by a recurrent ischaemic event. If a recurrent ischaemic event precipitates a readmission with an associated CABG undertaken, one of codes 1–4 should be coded.

*Verification rules:*

*Collection methods:*

***Related metadata:*** Is qualified by Acute coronary syndrome stratum, version 1

Is qualified by the data element Concurrent clinical condition — on presentation, version 1

Is used in conjunction with Heart rhythm type, version 1

Is qualified by Separation date, version 5

Is qualified by Date patient presents, version 2

***Information model:*** NHIM Request for/entry into service 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

***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:***

# Received radiation dose

## Identifying and definitional attributes

***Knowledgebase ID:*** ***001074*** ***Version number:*** ***1***

***Metadata type:*** Data element

| | |
|---|---|
| ***Definition:*** | The received dose of radiation measured in Gray (Gy) — ICRU. |
| ***Context:*** | This item is collected for the analysis of outcome by treatment type. |

## Relational and representational attributes

| | | | |
|---|---|---|---|
| ***Data type:*** | Numeric | ***Maximum field size:*** | 5 |
| ***Representational class:*** | Quantitative value | ***Format:*** | NNNNN |

***Data domain:*** Valid numbers. Unit of measurement: Gy, or

| | |
|---|---|
| 00000 | if no radiation therapy was administered |
| 99999 | if radiation therapy was administered but the dose is unknown |

***Guide for use:*** The ICRU50 reference dose should be recorded for photon therapy if available, otherwise a description of the received dose at the centre of the planning target volume. The ICRU58 should be recorded for brachytherapy. The International Council for Radiation Protection (ICRP) recommends recording doses at the axis point where applicable (opposed fields, four field box, wedged pairs and so on). For maximum consistency in this field the IRCP recommendations should be followed whenever possible.

***Verification rules:***

***Collection methods:***

***Related metadata:*** Relates to the data element concept Initial treatment episode for cancer, version 1.

Relates to the data element Radiotherapy treatment type, 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 Service provision 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.

***Source document:*** 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:***

# Referral from specialised mental health residential care

## Identifying and definitional attributes

| | | | |
|---|---|---|---|
| ***Knowledgebase ID:*** | ***001003*** | ***Version number:*** | ***1*** |
| ***Metadata type:*** | Data element | | |

| | |
|---|---|
| ***Definition:*** | The type of health care the resident is referred to by the residential care service for further care at the end of residential stay. |
| ***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:***

1 Specialised mental health admitted patient care
2 Specialised mental health residential care
3 Specialised mental health ambulatory care
4 Private psychiatrist care
5 General practitioner care
6 Other care
7 Not referred
8 Not applicable (i.e. end of reference period)
9 Unknown/not stated/inadequately described

***Guide for use:*** Where the resident is referred to two or more types of health care, the type of health care provided by the service primarily responsible for the care of the resident is to be reported.

***Verification rules:***

***Collection methods:***

***Related metadata:***

***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:*** | | | |

# Region of first recurrence

## Identifying and definitional attributes

| | | | |
|---|---|---|---|
| *Knowledgebase ID:* | *001075* | *Version number:* | *1* |
| *Metadata type:* | Data element | | |

| | |
|---|---|
| *Definition:* | The term recurrence refers to the return or reappearance of the primary cancer after a disease-free intermission or remission. The cancer may recur in more than one site (eg., both regional and distant metastases). |
| *Context:* | This item is collected for the analysis of outcome by treatment type. |

## Relational and representational attributes

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

*Data domain:*

| Code | Description |
|---|---|
| 0 | None, patient is disease-free |
| 1 | Local |
| 2 | Regional |
| 3 | Both local and regional |
| 4 | Distant |
| 5 | Distant and either local or regional |
| 6 | Local, regional and distant |
| 7 | Patient was never disease-free |
| 8 | Recurred but site unknown |
| 9 | Unknown if recurred |

*Guide for use:* The region of the first recurrence following the initial diagnosis should be recorded.

The record should not be updated with subsequent recurrences.

Record the highest numbered applicable response.

*Verification rules:*

*Collection methods:*

*Related metadata:* Relates to the data element Date of diagnosis of first recurrence, version 1.

*Information model link:* NHIM Physical wellbeing

| *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.

***Source document:*** Commission on Cancer. *Standards of the Commission on Cancer Volume II Registry Operations and Data Standards (ROADS)* (1998).

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

***Steward:***

***Comments:***

# Regional lymph nodes examined

## Identifying and definitional attributes

| | | | |
|---|---|---|---|
| *Knowledgebase ID:* | *001076* | *Version number:* | *1* |
| *Metadata type:* | Data element | | |

| | |
|---|---|
| *Definition:* | This records the total number outcome of regional lymph nodes examined by the pathologist. |
| *Context:* | |

## Relational and representational attributes

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

*Data domain:*

| Code | Description |
|---|---|
| 0 | No regional lymph nodes examined |
| 1–89 | Actual number of regional lymph nodes examined |
| 90 | Ninety or more regional lymph nodes examined |
| 95 | No regional lymph node(s) removed, but aspiration of regional lymph node(s) was performed |
| 96 | Regional lymph node removal documented as sampling but number unknown/not stated |
| 97 | Regional lymph nodes removal documented as dissection but number unknown/not stated |
| 98 | Regional lymph nodes removal but number unknown/not stated and not documented as sampling or dissection |
| 99 | Unknown; not stated; death certificate only |

*Guide for use:*

Code 95 No regional lymph node(s) removed, but aspiration of regional lymph node(s) was performed, is used for a lymph node aspiration when cytology or histology is positive for malignant cells

Code 99 Unknown; not stated; death certificate only, is used if information about regional lymph nodes is unknown or if the field is not applicable for that site or histology

*Verification rules:*

*Collection methods:*

*Related metadata:* Relates to the data element Cancer staging — N stage code, version 1.

Relates to the data element Regional lymph nodes positive, version 1.

*Information model link:* NHIM Service provision 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:*** Australian Cancer Network.

Commission on Cancer, American College of Surgeons.

***Source document:*** Australian Cancer Network *The pathology reporting of breast cancer. A guide for pathologists, surgeons and radiologists* Second Edition Sydney (2001).

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:***

# Regional lymph nodes positive

## Identifying and definitional attributes

***Knowledgebase ID:*** ***001077*** ***Version number:*** ***1***

***Metadata type:*** Data element

| | |
|---|---|
| ***Definition:*** | The number of regional lymph nodes examined by the pathologist and reported as containing tumour. |
| ***Context:*** | |

## Relational and representational attributes

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

***Data domain:***

| | |
|---|---|
| 0 | all nodes examined negative |
| 1–95 | actual number of regional lymph nodes positive |
| 96 | ninety-six or more lymph nodes positive |
| 97 | positive nodes but number not specified |
| 98 | no nodes examined |
| 99 | unknown if nodes are positive or negative; not applicable |

***Guide for use:***

| | |
|---|---|
| Code 97 | positive nodes but number not specified, is used when the cytology or hitology from a lymph node aspiration is positive for malignant cells. |
| Code 98 | positive nodes but number not specified, is used when no nodes are removed or examined. |
| Code 99 | unknown if nodes are positive or negative, is used if information about regional lymph nodes is unknown or if it is not applicable for that site or histology. |

***Verification rules:***

***Collection methods:***

***Related metadata:*** Relates to the data element Cancer staging — N stage code, version 1.

Relates to the data element Regional lymph nodes examined, version 1.

***Information model link:*** NHIM Physical wellbeing

| ***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:*** Australian Cancer Network.

Commission on Cancer, American College of Surgeons.

***Source document:*** Australian Cancer Network *The pathology reporting of breast cancer. A guide for pathologists, surgeons and radiologists* Second Edition Sydney (2001).

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:***

# Resident

## Identifying and definitional attributes

***Knowledgebase ID:*** ***000892*** ***Version number:*** ***1***

***Metadata type:*** Data element concept

| | |
|---|---|
| ***Definition:*** | A person who receives residential care intended to be for a minimum of one night. |
| ***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:***

***Information model link:*** NHIM Recipient role

## Administrative attributes

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

***Source organisation:***

***Source document:***

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

***Steward:***

***Comments:*** A resident in one residential mental health service cannot be concurrently a resident in another residential mental health service. A resident in a residential mental health service can be concurrently a patient admitted to a hospital.

# Residential mental health service

## Identifying and definitional attributes

***Knowledgebase ID:*** ***000899*** ***Version number:*** ***1***

***Metadata type:*** Data element concept

***Definition:*** A residential mental health service is a specialised mental health service that:

- employs mental health-trained staff on-site;
- provides rehabilitation, treatment or extended care;
  - to residents provided with care intended to be on an overnight basis;
  - in a domestic-like environment; and
- encourages the resident to take responsibility for their daily living activities.

These services include those that employ mental health trained staff on-site 24 hours per day and other services with less intensive staffing. However all these services employ on-site mental health trained staff for some part of each day.

***Context:*** Specialised mental health services.

## 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 Specialised mental health service, version 1.

Relates to the data element concept Resident, version 1.

***Information model link:*** NHIM Service delivery setting

## Administrative attributes

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

***Source organisation:***

***Source document:***

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

***Steward:***

***Comments:***

# Residential stay

## Identifying and definitional attributes

| | | | |
|---|---|---|---|
| *Knowledgebase ID:* | ***001000*** | ***Version number:*** | ***1*** |
| *Metadata type:* | Data element concept | | |

| | |
|---|---|
| *Definition:* | The period of care beginning with a formal start of residential care and ending with a formal end of the residential care and accommodation. May involve more than one reference period, that is, more than one episode of residential care. |
| *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, version 1.

Relates to the data element concept Resident, version 1.

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

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

Relates to the data element Residential stay start date, version 1.

*Information model link:* NHIM Service provision event

## Administrative attributes

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

*Source organisation:*

*Source document:*

*Registration authority:* National Health Information Group.

*Steward:*

*Comments:*

# Residential stay start date

## Identifying and definitional attributes

| | | | |
|---|---|---|---|
| *Knowledgebase ID:* | *001001* | *Version number:* | *1* |
| *Metadata type:* | Data element | | |

| | |
|---|---|
| *Definition:* | Date on which a resident formally started a residential stay. |
| *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.

Residential stay start date must be less than or equal to episode of residential care end date.

Residential stay 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 Episode of residential care start date, 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:*