Specialised mental health service

Identifying and definitional attributes

Knowledgebase ID: ***001002*** *Version number:* ***1***

Metadata type: Data element concept

Definition:	Specialised mental health services are those with a primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental disorder or psychiatric disability. These activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health care function. The concept of a specialised mental health service is not dependent on the inclusion of the service within the state or territory mental health budget. A service is not defined as a specialised mental health service solely because its clients include people affected by a mental disorder or psychiatric disability. The definition excludes specialist drug and alcohol services and services for people with intellectual disabilities, except where they are established to assist people affected by a mental disorder who also have drug and alcohol related disorders or intellectual disability. These services can be a sub-unit of a hospital even where the hospital is not a specialised mental health establishment itself (e.g. designated psychiatric units and wards, outpatient clinics etc.).
Context:	Hospitals and community mental health establishments and residential mental health establishments.

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 Establishment identifier, version 1.

Relates to the data element Establishment type, version 1.

Relates to the data element concept Residential mental health services, 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:

Specialised mental health service setting

Identifying and definitional attributes

Knowledgebase ID:	***001004***	***Version number:***	***1***
Metadata type:	Data element		

Definition:	The setting for care provided by a specialised mental health service.
Context:	Specialised mental health services.

Relational and representational attributes

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

Data domain:

1 Admitted patient care setting
2 Residential care setting
3 Ambulatory care setting
9 Unknown/not stated/inadequately described

Guide for use:

To be reported for specialised mental health establishments only, as defined in the Specialised mental health service data element concept.

A single mental health establishment may provide care in more than one setting. This data element is intended to allow staffing, resource and expenditure data related to these settings to be identified and reported separately.

Code 1 Admitted patient care setting:

The component of specialised mental health services that provides admitted patient care. These are specialised psychiatric hospitals and specialist psychiatric units located within hospitals that are not specialised psychiatric hospitals. Excludes hospital outpatient clinics.

Code 2 Residential care setting:

The component of specialised mental health services that provides residential care within residential mental health services. Excludes components that provide ambulatory care to patients or clients who are not residents.

Code 3 Ambulatory care setting:

The component of specialised mental health services that provides ambulatory care (service contacts). They include hospital outpatient clinics and non-hospital community mental health services.

Verification rules:

Collection methods:

Related metadata:

Relates to the data element concept Admitted patient, version 3.

Relates to the data element Establishment identifier, version 4.

Relates to the derived data element Establishment type, version 1.

Relates to the data element concept Residential mental health service, version 1.

Relates to Service the data element concept contact, version 1.

Relates to the data element concept Specialised mental health service, version 1.

Is used in conjunction with the derived data element Full-time equivalent staff, version 2.

Is used in conjunction with the derived data element Non-salary operating costs, version 1.

Is used in conjunction with the data element Number of available beds for admitted patients, version 2.

Is used in conjunction with the data element Salaries and wages, version 1.

Information model link: NHIM Service delivery setting

Data set specifications:	***Start date***	***End date***
NMDS — Community mental health establishments	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: Only domain values 2, 3 and 9 are to be used for Community mental health establishments NMDS. Domain value 1 is not applicable.

Specialist private sector rehabilitation care indicator

Identifying and definitional attributes

Knowledgebase ID:	***001006***	***Version number:***	***1***
Metadata type:	Data element		

Definition:	An indicator of whether the rehabilitation care that a patient receives from a private hospital meets the criteria for 'Specialist private sector rehabilitation care' (as determined by the Australian Government Department of Health and Ageing).
Context:	Admitted and non-admitted patients receiving rehabilitation care from a private hospital.

Relational and representational attributes

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

Data domain:	1	Yes
	2	No

Guide for use:

This data element is a qualifier of the three 'Rehabilitation' Care types (NHDD Version 12, page 94) for admitted patients in private hospitals. When an admitted patient in a private hospital is receiving Rehabilitation care (as defined in Care type), this data element should be recorded to denote whether or not that care meets the criteria for 'specialist rehabilitation'.

These are the criteria determined by The Australian Government Department of Health and Ageing in respect of patients treated in the private sector, specialist rehabilitation is:

- provided by a specialist rehabilitation unit (a separate physical space and a specialist rehabilitation team providing admitted patient and/or ambulatory care) meeting guidelines issued by the Australian Government Department of Health and Ageing; and
- provided by a multi-disciplinary team which is under the clinical management of a consultant in rehabilitation medicine or equivalent; and
- provided for a person with limited functioning (impairments, activity limitation and participation restrictions) and for whom there is a reasonable expectation of functional gain; and
- for whom the primary treatment goal is improvement in functional status which is evidenced in the medical record by:
  - an individualised and documented initial and periodic assessment of functional ability, or
  - an individualised multi-disciplinary rehabilitation plan which includes agreed rehabilitation goals and indicative timeframes.

Verification rules:

Collection methods:

Related metadata: Qualified by data element Care type, Version 4.

Information model link: NHIM Assessment event

Administrative attributes

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

Source organisation: Private Rehabilitation Working Group

Source document: World Health Organization. *International Classification of Functioning*, Disability and Health (ICF) — Geneva, 2001.

Registration authority: National Health Information Group.

Steward:

Comments: This definition has been developed by the Private Rehabilitation Working Group, and agreed by the private rehabilitation hospital sector, the private health insurance sector and the Australian Government Department of Health and Ageing.

Whilst most patients will be treated by a consultant in rehabilitation medicine (a Fellow of the Australasian Faculty of Rehabilitation Medicine) there are circumstances in which the treating doctor will not be a Fellow of the Faculty. These include, but are not limited to, care provided in geographic areas where there is a shortage of Fellows of the Australasian Faculty of Rehabilitation Medicine.

Staging basis

Identifying and definitional attributes

Knowledgebase ID:	***001079***	***Version number:***	***1***
Metadata type:	Data element		

Definition:	This data element describes the timing and evidence for T, N and M stage values.
Context:	For survival analysis adjusted by stage at diagnosis and distribution of cancer cases by type and stage.

Relational and representational attributes

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

Data domain:

P	Pathological
C	Clinical

Guide for use:

Clinical stage is based on evidence obtained prior to treatment from physical examination, imaging, endoscopy, biopsy, surgical exploration or other relevant examinations.

Pathological stage is based on histological evidence acquired before treatment, supplemented or modified by additional evidence acquired from surgery and from pathological examination.

Refer to the UICC reference manual *TNM Classification of Malignant Tumours* for coding rules.

Verification rules:

Collection methods: From information provided by the treating doctor and recorded on the patient's medical record.

Related metadata:

Relates to the data element Cancer staging — T stage code, version 1.

Relates to the data element Cancer staging — N stage code, version 1.

Relates to the data element Cancer staging — M stage code, version 1.

Relates to the data element Cancer staging — TNM stage grouping code, version 1.

Relates to the data element Staging scheme source, version 1.

Relates to the data element Staging scheme edition number, 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: International Union Against Cancer (UICC).

Source document: UICC *TNM Classification of Malignant Tumours* (5th Edition) (1997).

Registration authority: National Health Information Group.

Steward:

Comments:

Staging scheme source

Identifying and definitional attributes

Knowledgebase ID:	***001080***	***Version number:***	***1***
Metadata type:	Data element		

Definition: The staging scheme source is the reference which describes in detail the methods of staging and the definitions for the classification system used in determining the extent of cancer at the time of diagnosis.

Context: For survival analysis adjusted by stage at diagnosis and distribution of cancer cases by type and stage.

Relational and representational attributes

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

Data domain:

1	TNM Classification of Malignant Tumours (UICC)
2	Durie & Salmon for multiple myeloma staging
3	FAB for leukaemia classification
4	Australian Clinico-Pathological Staging (ACPS) System
8	other
9	unknown

Guide for use: It is recommended that the *TNM Manual of the UICC* be used whenever it is applicable. The classifications published in the American Joint Committee on Cancer (AJCC) *Cancer Staging Manual* are identical to the TNM classifications of the UICC.

TNM is not applicable to all tumour sites. Staging is of limited use in acute leukaemias, although a staging system is used for chronic lymphocytic leukaemia. Separate staging systems exist for lymphomas and myeloma. The recently published *NHMRC Guidelines for the Prevention, Early Detection and Management of Colorectal Cancer (CRC)* support the use of the Australian Clinico-Pathological Staging (ACPS) System. A table of correspondences between ACPS and TNM classifications is available.

The current edition of each staging scheme should be used.

Verification rules:

Collection methods:

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

Is used in conjunction with data element Staging scheme source edition number, 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:

International Union Against Cancer (UICC).

FAB (French-American-British) Group.

NSW Health Department.

National Health & Medical Research Council.

Clinical Oncological Society of Australia.

Australian Cancer Network.

Source document:

UICC *TNM Classification of Malignant Tumours (5th Edition)* (1997)

Durie BGM, Salmon SE. *A clinical staging system for multiple myeloma correlation of measured myeloma cell mass with presenting clinical features, response to treatment and survival.* Cancer 36:842–54 (1975).

Bennett JM, Catovsky D, Daniel MT, Flandrin G, Galton DA, Gralnick HR, Sultan C. *Proposed revised criteria for the classification of acute myeloid leukemia: a report of the French-American-British Cooperative Group*. Ann Intern Med 103(4): 620-625 (1985).

Cheson BD, Cassileth PA, Head DR, Schiffer CA, Bennett JM, Bloomfield CD, Brunning R, gale RP, Grever MR, Keating MJ, et al. *Report of the National Cancer Institute-sponsored workshop on definitions of diagnosis and response in acute myeloid leukemia*. J Clin Oncol 8(5): 813–819 (1990).

Davis NC, Newland RC. *The reporting of colorectal cancer: the Australian Clinicopathological Staging system*. Aust NZ J Surg 52:395–397 (1982).

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

NHMRC Guidelines for the prevention, early detection and management of colorectal cancer (CRC) (1999).

Registration authority: National Health Information Group.

Steward:

Comments:

Staging scheme source edition number

Identifying and definitional attributes

Knowledgebase ID:	***001081***	***Version number:***	***1***
Metadata type:	Data element		

Definition:	Staging scheme source edition number identifies the edition of the reference used for the purposes of staging the cancer.
Context:	For survival analysis adjusted by stage at diagnosis and distribution of cancer cases by type and stage.

Relational and representational attributes

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

Data domain:	1-87	Edition number
	88	Not applicable (Cases that do not have a recommended staging scheme)
	99	Unknown edition

Guide for use:

Verification rules:

Collection methods:

Related metadata: Used in conjunction with the data element Staging scheme source, 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: 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:

Street name

Identifying and definitional attributes

Knowledgebase ID: ***001014*** ***Version number:*** ***1***

Metadata type: Data element

Definition: The name that identifies a public thoroughfare and differentiates it from others in the same suburb/town/locality.

Context: Australian addresses.

Relational and representational attributes

Data type: Alphabetic ***Maximum field size:*** 30

Representational class: Text ***Format:*** A(30)

Data domain: Free text.

Guide for use: To be used in conjunction with Street type code.

To be used in conjunction with Street suffix code.

Verification rules:

Collection methods:

Related metadata: Relates to the data element Street Type Code, version 1.

Relates to the data element Street Suffix Code, version 1.

Relates to the data element House/Property 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: Where Suburb/town/locality name, Australian state/territory and Postcode — Australia are insufficient to assign a Statistical Local Area (SLA) code from the Australian Standard Geographical Classification (Australian Bureau of Statistics, Cat. No. 1216.0), the Street name element in conjunction with Street type code, House/property number and Street suffix code should also be used.

Street suffix code

Identifying and definitional attributes

Knowledgebase ID:	***001015***	***Version number:***	***1***
Metadata type:	Data element		

Definition: Term used to qualify Street name used for directional references.

Context: Australian addresses.

Relational and representational attributes

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

Data domain:

CN	Central
E	East
EX	Extension
LR	Lower
N	North
NE	North East
NW	North West
S	South
SE	South East
SW	South West
UP	Upper
W	West

Guide for use:

Verification rules:

Collection methods: To be used in conjunction with Street name.

To be used in conjunction with Street type code.

For example:

Browns Rd W.

Related metadata: Relates to the data element Street name, version 1.

Relates to the data element Street type code, version 1.

Relates to the data element House/property 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:	AS4590 Interchange of client information. Australia Post Address Presentation Standard.		
Registration authority:	National Health Information Group.		
Steward:	Health Data Standards Committee.		
Comments:			

Street type code

Identifying and definitional attributes

Knowledgebase ID:	***001016***	***Version number:***	***1***
Metadata type:	Data element		

Definition:	A code that identifies the type of public thoroughfare.
Context:	Australian addresses.

Relational and representational attributes

Data type:	Alphabetic	***Maximum field size:***	4
Representational class:	Code	***Format:***	A(4)

Data domain: Valid Street type codes as defined by AS4590.

Guide for use:

Verification rules:

Collection methods: To be collected in conjunction with Street name.
To be collected in conjunction with Street suffix code.

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: Standards Australia.
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: The following is a list of commonly used abbreviations from AS 4590:

Street type	**Abbreviation**
Alley	Ally
Arcade	Arc
Avenue	Ave

Comments (continued):

Boulevard	Bvd
Bypass	Bypa
Circuit	Cct
Close	Cl
Corner	Crn
Court	Ct
Crescent	Cres
Esplanade	Esp
Green	Grn
Grove	Gr
Highway	Hwy
Junction	Jnc
Lane	Lane
Link	Link
Mews	Mews
Parade	Pde
Place	Pl
Ridge	Rdge
Road	Rd
Square	Sq
Street	St
Terrace	Tce

Surgical treatment procedure for cancer

Identifying and definitional attributes

Knowledgebase ID:	***001082***	***Version number:***	***1***
Metadata type:	Data element		

Definition:	The surgical procedure(s) used in the primary treatment of the cancer.
Context:	This item is collected for determining outcome by treatment type.

Relational and representational attributes

Data type:	Numeric	***Maximum field size:***	8
Representational class:	Code	***Format:***	NNNNN-NN

Data domain:	Current edition of ICD-10-AM procedure codes

Guide for use:

Each surgical treatment procedure used in the initial treatment of the cancer should be recorded. Surgical procedures performed for palliative purposes only should not be included.

For surgical procedures involved in the administration of another modality (e.g. implantation of infusion pump, isolated limb parfusion/infusion, intra-operative radiotherapy) record both the surgery and the other modality.

Any systemic treatment which can be coded as a procedure through ICD-10-AM should be so coded (e.g. stem cell or bone marrow infusion).

The Australian Classification of Health Interventions (ACHI), which is a part of ICD-10-AM, can be used to classify procedures.

Verification rules:

Collection methods:

Related metadata:

Relates to the data element concept Initial treatment episode for cancer, version 1.

Relates to the data element Date of surgical treatment for cancer, version 1.

Relates to the data element Intention of treatment for cancer, 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:

National Centre for Classification in Health.

NSW Department of Health, Public Health Division.

Source document: Current edition of *International Classification of Diseases*, Australian Modification, National Centre for Classification in Health, Sydney (ICD-10-AM).

NSW Department of Health NSW *Clinical Cancer Data Collection for Outcomes and Quality.* Data Dictionary Version 1 (2001).

Registration authority: National Health Information Group.

Steward:

Comments:

Systemic therapy agent name

Identifying and definitional attributes

Knowledgebase ID:	***001083***	***Version number:***	***1***
Metadata type:	Data element		

Definition: The standard chemotherapeutic agent or anti-cancer drug used for treatment of the primary cancer.

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

Collecting dates for systemic therapy will allow evaluation of treatments delivered and of time intervals from diagnosis to treatment, from treatment to recurrence and from treatment to death.

Relational and representational attributes

Data type:	Alphanumeric	***Maximum field size:***	14
Representational class:	Code	***Format:***	AAAAAAAAAAAAAA

Data domain: Codes from the Surveillance, Epidemiology and End Results (SEER) Program *Self-instructional manual for tumour registrars: Book 8 – Antineoplastic drugs*, third edition, National Cancer Institute.

Guide for use: The purpose of collecting specific treatment information is to account for all treatment types, which may assist in evaluation of effectiveness of different treatment patterns. The actual agents used will sometimes be of interest.

Systemic therapy often involves treatment with a combination of agents. These may be known by acronyms but since details of drugs and acronyms may vary it is recommended that each agent be recorded separately.

Oral chemotherapy normally given on an outpatient basis should also be included.

New codes and names will need to be added as new agents become available for clinical use.

Hormone therapy agents and immunotherapy agents should be recorded under this data element.

Verification rules:

Collection methods: The full name of the agent(s) should be recorded if the coding manual is not available.

Related metadata: Relates to the data element 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.

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: National Cancer Institute Surveillance, Epidemiology and End Results (SEER) Program.

Source document: Surveillance, Epidemiology and End Results (SEER) Program *Self-instructional manual for tumour registrars: Book 8 – Antineoplastic drugs,* third Edition National Cancer Institute.

Registration authority: National Health Information Group.

Steward:

Comments:

Time creatine kinase MB isoenzyme (CK-MB) measured

Identifying and definitional attributes

Knowledgebase ID:	***001048***	*Version number:*	***1***
Metadata type:	Data element		

Definition:	The time at which the creatine kinase MB isoenzyme (CK-MB) was measured.
Context:	Health care and clinical settings.

Relational and representational attributes

Data type:	Numeric	*Maximum field size:*	4
Representational class:	Time	*Format:*	HHMM

Data domain:	Time in 24-hour clock format.

Guide for use:

Verification rules:

Collection methods:

Related metadata: Is used in conjunction with Creatine kinase MB isoenzyme (CK-MB) — measured, version 1

Is used in conjunction with Date Creatine kinase MB isoenzyme (CK-MB) measured, version 1

Information model: NHIM Service provision event

Data set specifications:		*Start date*	*End date*
DSS —	Acute coronary syndrome data set (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:

Time of first angioplasty balloon inflation or stenting

Identifying and definitional attributes

Knowledgebase ID:	***001049***	***Version number:***	***1***
Metadata type:	Data element		

Definition:	The time of the first angioplasty balloon inflation or stent placement.
Context:	Health care and clinical settings.

Relational and representational attributes

Data type:	Numeric	***Maximum field size:***	4
Representational class:	Time	***Format:***	HHMM

Data domain: Time in 24-hour clock format.

Guide for use: For Acute coronary syndrome (ACS) reporting, refers to coronary arteries.

Verification rules:

Collection methods:

Related metadata:

Is used in conjunction with the data element Date of first angioplasty balloon inflation or stenting, version 1.

Is used in conjunction with the data element Date of triage, version 1.

Is used in conjunction with the data element Time of triage, version 1.

Is used in conjunction with the data element Acute coronary syndrome procedure 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:

Time of intravenous fibrinolytic therapy

Identifying and definitional attributes

Knowledgebase ID:	***001050***	*Version number:*	***1***
Metadata type:	Data element		

Definition:	The time intravenous (IV) fibrinolytic therapy was first administered.
Context:	Health care and clinical settings.

Relational and representational attributes

Data type:	Numeric	*Maximum field size:*	4
Representational class:	Time	*Format:*	HHMM

Data domain:	Time in 24-hour clock format. 9999 Not stated/inadequately described

Guide for use: For Acute coronary syndrome (ACS) reporting, refers to coronary arteries. If initiated by a bolus dose whether in a pre-hospital setting, emergency department or inpatient unit/ward, the time the initial bolus was administered should be reported.

Verification rules:

Collection methods:

Related metadata:

Is used in conjunction with the data element Fibrinolytic therapy status, version 1.

Is used in conjunction with the data element Date of intravenous fibrinolytic therapy, version 1.

Is used in conjunction with the data element Fibrinolytic drug used, version 1.

Is used in conjunction with the data element Date of triage, version 1.

Is used in conjunction with the data element Time of triage, 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:

Time troponin measured

Identifying and definitional attributes

Knowledgebase ID:	***001051***	*Version number:*	***1***
Metadata type:	Data element		

Definition:	The time at which the troponin (T or I) was measured.
Context:	Health care and clinical settings.

Relational and representational attributes

Data type:	Numeric	*Maximum field size:*	4
Representational class:	Time	*Format:*	HHMM

Data domain:	Time in 24-hour clock format.

Guide for use: This data element pertains to the measuring of troponin at any time point during this current event.

Verification rules:

Collection methods:

Related metadata: Is used in conjunction with the data element Date troponin measured, version 1.

Is used in conjunction with the data element Troponin measured, 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:

Troponin assay type

Identifying and definitional attributes

Knowledgebase ID:	***001052***	***Version number:***	***1***
Metadata type:	Data element		

Definition: Identifies the type of troponin assay (I or T) used to assess the person's troponin levels.

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	Cardiac troponin T (cTnT)
2	Cardiac troponin I (cTnI)
8	Not taken
9	Not stated/inadequately described

Guide for use: For Acute coronary syndrome (ACS) reporting, identifies the type of troponin assay (I or T) used to assess troponin levels during this presentation.

Verification rules:

Collection methods:

Related metadata: Is used in conjunction with the data element Troponin measured, version 1.

Is used in conjunction with the data element Troponin assay—upper limit of normal range, version 1.

Is used in conjunction with the data element Time troponin measured, version 1.

Is used in conjunction with the data element Date troponin measured, 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:

Troponin assay — upper limit of normal range

Identifying and definitional attributes

Knowledgebase ID:	***001053***	*Version number:*	***1***
Metadata type:	Data element		

Definition:	Laboratory standard for the value of 'troponin T' or 'troponin I' that is the upper boundary of the normal reference range.
Context:	Health care and clinical settings.

Relational and representational attributes

Data type:	Numeric	*Maximum field size:*	4
Representational class:	Quantitative value	*Format:*	NNNN

Data domain: µg/L upper limit value that is constant for the laboratory performing the test

9999 Not stated/Inadequately described.

Guide for use: Record the upper limit of normal (usually the ninety-ninth percentile of a normal population) for the individual laboratory.

Verification rules:

Collection methods:

Related metadata:
Is used in conjunction with Troponin measured, version 1
Is used in conjunction with Troponin — assay type, version 1.
Is used in conjunction with Time troponin measured, version 1.
Is used in conjunction with Date troponin measured, 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

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:

Troponin measured

Identifying and definitional attributes

Knowledgebase ID:	***001054***	***Version number:***	***1***
Metadata type:	Data element		

Definition: A person's measured troponin.

Context: Health care and clinical settings.

Relational and representational attributes

Data type:	Numeric	***Maximum field size:***	5
Representational class:	Quantitative value	***Format:***	NN.NN

Data domain: Troponin measured in µg/L, or

8888 Not measured

9999 Not stated/ inadequately defined

Guide for use: Code 8888 if test for troponin (T or I) was not done.

Measured in different assays dependant upon laboratory methodology.

When only one troponin level is recorded, this should be the peak level during the admission.

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

Verification rules:

Collection methods:

Related metadata: Is a qualifier of the data element Acute coronary syndrome stratum, version 1.

Is used in conjunction with the data element Date troponin measured, version 1.

Is used in conjunction with the data element Time troponin measured, version 1.

Is used in conjunction with the data element Troponin — assay type, version 1.

Is used in conjunction with the data element Troponin assay — upper level of normal, version 1.

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