

Modified data elements

The following data elements were amended to rectify errors which existed in Version 12 of the NHDD:

- Actual place of birth
- Intended place of birth
- Previous pregnancies.

Address data items

Standards Australia recently published the standard for the Health Care Client Identifier (AS-5017) in which address components form part of a set of data elements to unambiguously identify a health care client. This has resulted in the creation of complementary data elements that support 'Address' in such a way as to ensure there is no ambiguity in the data collected.

Admitted patient care NMDS

Following the evaluation of the Admitted patient Care NMDS to assess the quality and utility of the NMDS to determine whether the data collection suits current requirements and identify changes required to improve data quality and comparability, modifications were made to the following data items:

- Activity when injured
- Australian state/territory identifier
- Episode of admitted patient care
- Inter-hospital contracted patient
- Place of occurrence of external cause of injury.

Alcohol and other drug treatment services NMDS

As a result of the Inter-Governmental Committee on Drugs Working Group Alcohol and Drug Treatment Services NMDS 2003 meeting, all the data elements and supporting data element concepts from the Alcohol and drug Treatment NMDS were reviewed. The working group concluded that following data items required modification:

- Establishment sector
- Main treatment type for alcohol and other drugs
- Number of service contacts within a treatment episode for alcohol and other drugs
- Other treatment type for alcohol and other drugs
- Other drug of concern
- Principal drug of concern
- Reason for cessation of treatment episode for alcohol and other drugs
- Service contact

- Source of referral to alcohol and other drug treatment service
- Treatment delivery setting for alcohol and other drugs
- Treatment episode for alcohol and other drugs.

'Foetus' to 'Fetus' modification

The Health Data Standards Committee proposed that American spelling be used when referring to 'foetus' and 'foetal'. This resulted in the modification of the following data items:

- Birth plurality
- Birthweight
- Complications of pregnancy
- Outcome of last previous pregnancy
- Maternal medical conditions
- Pregnancy – current status
- Presentation at birth
- Status of the baby
- Still birth (fetal death).

Integrated data items

The following data elements from the *National Health Data Dictionary* and the *National Community Services Data Dictionary* were identified as having many shared attributes and have therefore been integrated for both health and community services use.

- Australian state/territory identifier
- Country of birth
- Date of birth
- Family name
- Given name(s)
- Indigenous status
- Informal carer availability
- Labour force status
- Main language other than English spoken at home
- Main occupation of person
- Marital status
- Mother's original family name
- Name context flag
- Name suffix
- Name title
- Person identifier
- Postal delivery point identifier
- Postcode – Australian

- Proficiency in spoken English
- Sex
- Suburb/tow/locality name
- Telephone number
- Telephone number type.

Residential mental health care NMDS

In order to facilitate the approved changes to the new Residential mental health care NMDS, the following data elements were modified:

- Additional diagnosis
- Australian state/territory identifier
- Diagnosis
- Mental health legal status
- Principal diagnosis.

Modify references to 'third edition ICD-10-AM' to 'current edition ICD-10-AM'

The following data items were modified to change any reference of 'third edition ICD-10-AM' to 'current edition ICD-10-AM':

- Activity when injured
- Additional diagnosis
- Complication of labour and delivery
- Complications of pregnancy
- Congenital malformations
- Date of procedure
- Diagnosis onset type
- External cause – admitted patient
- Indicator procedure
- Maternal medical conditions
- Neonatal morbidity
- Place of occurrence of external cause of injury
- Postpartum complication
- Primary site of cancer
- Principal diagnosis
- Procedure
- Vascular history
- Waiting list category.

Guide for use:	Non-admitted patients: To be used for injury surveillance purposes for non-admitted patients when it is not possible to use ICD-10-AM codes. Select the code which best characterises the type of activity being undertaken by the person when injured, on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one that comes first in the code list.
Verification rules:	Admitted patients: To be used with ICD-10-AM external cause codes.
Collection methods:	
Related metadata:	Is a qualifier of the data element Narrative description of injury event, version 1. Is used in conjunction with the data element Nature of main injury – non-admitted patient, version 1. Is used in conjunction with the data element Bodily location of main injury, version 1. Supersedes previous data element Activity when injured, version 1. Is used in conjunction with the data element External cause – human intent, version 4. Is used in conjunction with the data element External cause – non-admitted patient, version 4. Relates to the data element Diagnosis onset type, version 1.
Information model link:	NHIM Injury event

Data set specifications:	Start date	End date
NMDS – Admitted patient care	01/07/2004	
NMDS – Injury surveillance	01/07/2004	

Administrative attributes

Admin. status:	CURRENT	Effective Date:	05/12/2003
Source organisation:	National Centre for Classification in Health. National Injury Surveillance Unit.		
Source document:	Current edition of ICD-10-AM.		
Registration authority:	National Health Information Group.		
Steward:			
Comments:			

Actual place of birth

Identifying and definitional attributes

Knowledgebase ID: 000003 **Version number:** 2
Metadata type: Data element

Definition: The actual place where the birth occurred.

Context: Perinatal statistics:
 Used to analyse the risk factors and outcomes by place of birth. While most deliveries occur within hospitals, an increasing number of births now occur in other settings. It is important to monitor the births occurring outside hospitals and to ascertain whether or not the actual place of delivery was planned.

Relational and representational attributes

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

Data domain:

1	Hospital, excluding birth centre
2	Birth centre, attached to hospital
3	Birth centre, free standing
4	Home
8	Other
9	Not stated

Guide for use: This is to be recorded for each baby the mother delivers from this pregnancy.

Code 4 Home, should be reserved for those births that occur at the home intended.

Code 8 Other, used when birth occurs at a home other than that intended. May also include a community health centre or be used for babies 'born before arrival'.

Verification rules:

Collection methods:

Related metadata: Supersedes the previous data element Actual place of birth, version 1.
 Is a qualifier of the data element Intended place of birth, version 2.

Information model link: NHIM Other setting

Data set specifications:

	Start date	End date
NMDS – Perinatal	01/07/2001	

Administrative attributes

Admin. status: CURRENT *Effective Date:* 01/07/2001

Source organisation: National Perinatal Data Development Committee.

Source document:

Registration authority: National Health Information Group.

Steward:

Comments: The development of a definition of a birth centre is currently under consideration by the Commonwealth in conjunction with the states and Territories.

Additional diagnosis

Identifying and definitional attributes

Knowledgebase ID:	000005	Version number:	5
Metadata type:	Data element		

Definition:	A condition or complaint either coexisting with the principal diagnosis or arising during the episode of admitted patient care, episode of residential care or attendance at a health care establishment.
Context:	Additional diagnoses give information on factors which result in increased length of stay, more intensive treatment or the use of greater resources. They are used for casemix analyses relating to severity of illness and for correct classification of patients into Australian Refined Diagnosis Related Groups (AR-DRGs).

Relational and representational attributes

Data type:	Alphanumeric	Maximum field size:	6
Representational class:	Code	Format:	ANN.NN

Data domain:	ICD-10-AM – disease codes from ICD-10-AM current edition.
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Guide for use: Record each additional diagnosis relevant to the episode of care in accordance with the ICD-10-AM Australian Coding Standards. An unlimited number of diagnosis and procedure codes should be able to be collected in hospital morbidity systems. Where this is not possible, a minimum of 20 codes should be able to be collected. Generally, External cause, Place of occurrence and Activity codes will be included in the string of additional diagnosis codes. In some data collections these codes may also be copied into specific fields.

The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status.

Verification rules:

Collection methods: An additional diagnosis should be recorded and coded where appropriate upon separation of an episode of admitted patient care or the end of an episode of residential care. The additional diagnosis is derived from and must be substantiated by clinical documentation.

Related metadata: Supersedes previous data element Additional diagnosis, version 4.
Relates to the data element Diagnosis onset type, version 1.
Is used in the derivation of the data element Diagnosis related group, version 1.
Supplements the data element Principal diagnosis, version 4.

Information model link: NHIM Physical wellbeing

<i>Data set specifications:</i>	<i>Start date</i>	<i>End date</i>
NMDS – Admitted patient care	01/07/2004	
NMDS – Admitted patient mental health care	01/07/2004	
NMDS – Admitted patient palliative care	01/07/2004	
NMDS – Residential mental health care	01/07/2004	

Administrative attributes

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

Source organisation: National Centre for Classification in Health (Sydney).

Source document: Current edition of International Classification of Diseases, Tenth Revision, Australian Modification (ICD-10-AM).

Registration authority: National Health Information Group.

Steward:

Comments:

Address

Identifying and definitional attributes

Knowledgebase ID: 000799 *Version number:* 2
Metadata type: Data element concept

Definition: The referential description of a location where an entity is located or can be otherwise reached or found.

Context:

Relational and representational attributes

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

Data domain:

Guide for use: Following are the attributes that commonly qualify an address:

- Address line (composite data element – see the current version of the Address line metadata item for further description and a list of its components for addresses located in Australia)
- Post office box/mailbag number
- Postal delivery point identifier
- Australian state/territory identifier
- Suburb/town/locality
- Postcode – Australian
- Country identifier

Verification rules:

Collection methods:

Related metadata:

- Relates to the data element Address line, version 1.
- Relates to the data element Building/complex sub-unit type – abbreviation, version 1.
- Relates to the data element Building/complex sub-unit number, version 1.
- Relates to the data element Building/property name, version 1.
- Relates to the data element Floor/level type, version 1.
- Relates to the data element Floor/level number, version 1.
- Relates to the data element House/property number, version 1.
- Relates to the data element Lot/section number, version 1.
- Relates to the data element Postal delivery service type – abbreviation, version 1.
- Relates to the data element Postal delivery service number, version 1.
- Relates to the data element Street name, version 1.
- 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 Address type, version 1.
 Relates to the data element Postal delivery point identifier, version 2.
 Relates to the data element Australian state/territory identifier, version 4.
 Relates to the data element Suburb/town/locality name, version 2.

Information model link: NHIM Address element

<i>Data set specifications:</i>	<i>Start date</i>	<i>End date</i>
DSS - Health care client identification	25/02/2004	

Administrative attributes

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

Source organisation: Health Data Standards Committee.

Source document:

Registration authority: National Health Information Group.

Steward: Health Data Standards Committee.

Comments: Some attributes of an address, located within Australia, also provide the elements to determine the Statistical Local Area – SLA.

This enables:

- comparison of the use of services by persons residing in different geographical areas,
- characterisation of catchment areas and populations for facilities for planning purposes, and
- documentation of provision of services to clients who reside in other states or Territories.

The address is also a relevant element in the unambiguous identification of a Health Care Client and a Health Care Provider.

Australian state/territory identifier

Identifying and definitional attributes

Knowledgebase ID:	002025	Version number:	4
Metadata type:	Data element		

Definition:	An identifier of the Australian state or territory.
Context:	This is a geographic indicator which is used for analysis of the distribution of clients or patients, agencies or establishments and services.

Relational and representational attributes

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

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

Guide for use: When used specifically in the collection of address information for a client, the following local implementation rules may be applied: NULL may be used to signify an unknown address state; and Code 0 may be used to signify an overseas address.

The order presented here is the standard for the ABS. Other organisations (including the AIHW) publish data in state order based on population (that is, Western Australia before South Australia and Australian Capital Territory before Northern Territory).

Irrespective of how the information is coded, conversion of the codes to the ABS standard must be possible.

DSS – Health care client identification:

When used specifically in the collection of address information for a client, the following local implementation rules may be applied:

- NULL may be used to signify an unknown address state; and
- Code 0 may be used to signify an overseas address.

NMDS – Residential mental health care:

This is the state or territory of the establishment.

NMDS – Admitted patient care:

This data element applies to the location of the establishment and not to the patient's area of usual residence.

Verification rules:

Collection methods:

Related metadata: Supersedes previous data element state/territory identifier, version 3.
Is a composite part of Establishment identifier, version 4.

Information model link: NHIM Address element

Data set specifications:	Start date	End date
NMDS – Admitted patient care	01/07/2004	
DSS – Health care client identification	02/09/2003	

Administrative attributes

Admin. status: CURRENT **Effective Date:** 02/09/2003

Source organisation: Australian Institute of Health and Welfare.
Australian Bureau of Statistics.
Health Data Standards Committee.
National Community Services Data Committee.

Source document: Australian Bureau of Statistics 2001. *Australian Standard Geographical Classification (ASGC)*. Cat. no. 1216.0. Canberra: ABS.
Reference through:
<<http://www.abs.gov.au/Ausstats/abs@.nsf/StatsLibrary>>

Registration authority: National Health Information Group.
National Community Services Information Management Group.

Steward:

Comments: This metadata item is common to both the *National Health Data Dictionary* and the *National Community Services Data Dictionary*.

Birth plurality

Identifying and definitional attributes

Knowledgebase ID: 000020 **Version number:** 1
Metadata type: Data element

Definition: An indicator of multiple birth, showing the total number of births resulting from a single pregnancy.

Context: NMDS Perinatal:
 Multiple pregnancy increases the risk of complications during pregnancy, labour and delivery and is associated with higher risk of perinatal morbidity and mortality.

NMDS Health Care Client Identification:
 While this piece of information is normally recorded for multiple births against the mother's record, if the health care client volunteers the information, it should be recorded.

Relational and representational attributes

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

Data domain:

1	Singleton
2	Twins
3	Triples
4	Quadruplets
5	Quintuplets
6	Sextuplets
8	Other
9	Not stated

Guide for use: Plurality of a pregnancy is determined by the number of live births or by the number of fetuses that remain in utero at 20 weeks gestation and that are subsequently born separately. In multiple pregnancies, or if gestational age is unknown, only live births of any birthweight or gestational age, or fetuses weighing 400 g or more, are taken into account in determining plurality. Fetuses aborted before 20 completed weeks or fetuses compressed in the placenta at 20 or more weeks are excluded.

Verification rules:

Collection methods: This data should be collected routinely for persons aged 28 days or less.

Related metadata: Is qualified by the data element Birth order, version 2.

Information model link: NHIM Birth event

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

NMDS – Perinatal	01/07/1997
DSS – Health care client identification	01/01/2003

Administrative attributes

Admin. status: CURRENT *Effective Date:* 01/07/1996

Source organisation: National Perinatal Data Development Committee.

Source document:

Registration authority: National Health Information Group.

Steward:

Comments:

Birthweight

Identifying and definitional attributes

Knowledgebase ID: 000021 **Version number:** 1
Metadata type: Data element concept

Definition:	The first weight of the fetus or baby obtained after birth. The World Health Organization further defines the following categories: <ul style="list-style-type: none"> – Extremely low birthweight: less than 1,000 g (up to and including 999 g) – Very low birthweight: less than 1,500 g (up to and including 1,499 g) – Low birthweight: less than 2,500 g (up to and including 2,499 g)
Context:	Perinatal.

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 Birth event

Administrative attributes

Admin. status: CURRENT **Effective Date:** 01/07/1996

Source organisation: National Perinatal Data Development Committee.

Source document: *International Classification of Diseases and Related Health Problems, Tenth Revision, WHO, 1992.*

Registration authority: National Health Information Group.

Steward:

Comments: The definitions of low, very low, and extremely low birthweight do not constitute mutually exclusive categories. Below the set limits they are all-inclusive and therefore overlap (i.e. low includes very low and extremely low, while very low includes extremely low).
For live births, birthweight should preferably be measured within the first hour of life before significant postnatal weight loss has occurred.

While statistical tabulations include 500 g groupings for birthweight, weights should not be recorded in those groupings. The actual weight should be recorded to the degree of accuracy to which it is measured.

Complication of labour and delivery

Identifying and definitional attributes

Knowledgebase ID: 000027 **Version number:** 2
Metadata type: Data element

Definition:	Medical and obstetric complications (necessitating intervention) arising after the onset of labour and before the completed delivery of the baby and placenta.
Context:	Perinatal statistics: Complications of labour and delivery may cause maternal morbidity and may affect the health status of the baby at birth.

Relational and representational attributes

Data type: Alphanumeric **Maximum field size:** 6
Representational class: Code **Format:** ANN.NN

Data domain:	Current edition of ICD-10-AM.
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Guide for use: There is no arbitrary limit on the number of conditions specified.

Verification rules: Complications should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM.

Collection methods:

Related metadata: Supersedes previous data element Complication of labour and delivery – ICD-9-CM code, version 1.
 Is used in conjunction with the data element Presentation at birth, version 1.
 Is used in conjunction with the data element Method of birth, version 1.
 Is used in conjunction with the data element Perineal status, version 1.
 Is used in conjunction with the data element Postpartum complication, version 2.

Information model link: NHIM Birth event

Administrative attributes

Admin. status: CURRENT **Effective Date:** 01/07/1998

Source organisation: National Perinatal Data Development Committee.

Source document: *International Statistical Classification of Diseases and Related health Problems – Tenth Revision, Australian Modification (ICD-10-AM)*. National Centre for Classification in Health, Sydney.

Registration authority: National Health Information Group.

Steward:

Comments:

Complications of pregnancy

Identifying and definitional attributes

Knowledgebase ID: 000028 **Version number:** 2
Metadata type: Data element

Definition:	Complications arising up to the period immediately preceding delivery that are directly attributable to the pregnancy and may have significantly affected care during the current pregnancy and/or pregnancy outcome.
Context:	Perinatal statistics: Complications often influence the course and outcome of pregnancy, possibly resulting in hospital admissions and/or adverse effects on the fetus and perinatal morbidity.

Relational and representational attributes

Data type: Alphanumeric **Maximum field size:** 6
Representational class: Code **Format:** ANN.NN

Data domain:	Current edition of ICD-10-AM disease codes.
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Guide for use:

Verification rules: Complications should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM.

Collection methods:

Related metadata: Supersedes previous data element Complications of pregnancy – ICD-9-CM code, version 1.

Is used in conjunction with the data element Maternal medical conditions, version 2.

Information model link: NHIM Physical wellbeing

Administrative attributes

Admin. status: CURRENT **Effective Date:** 01/07/1998

Source organisation: National Perinatal Data Development Committee.

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

Registration authority: National Health Information Group.

Steward:

Comments:

Congenital malformations

Identifying and definitional attributes

Knowledgebase ID: 000030 **Version number:** 2
Metadata type: Data element

Definition:	Structural abnormalities (including deformations) that are present at birth and diagnosed prior to separation from care.
Context:	Admitted patient care: Required to monitor trends in the reported incidence of congenital malformations, to detect new drug and environmental teratogens, to analyse possible causes in epidemiological studies, and to determine survival rates and the utilisation of paediatric services.

Relational and representational attributes

Data type: Alphanumeric **Maximum field size:** 6
Representational class: Code **Format:** ANN.NN

Data domain:	Current edition of ICD-10-AM.
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Guide for use: Coding to the disease classification of ICD-10-AM is the preferred method of coding admitted patients. However, for the perinatal data collection, the use of BPA is preferred as this is more detailed (see the data element Congenital malformations – BPA classification).

Verification rules:

Collection methods:

Related metadata: Supersedes the previous data element Congenital malformations – ICD-9-CM code, version 1.
Is used in conjunction with the data element Neonatal morbidity, version 2.

Information model link: NHIM Physical wellbeing

Administrative attributes

Admin. status: CURRENT **Effective Date:** 01/07/1998

Source organisation: National Perinatal Data Development Committee.

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

Registration authority: National Health Information Group.

Steward:

Comments:

Country of birth

Identifying and definitional attributes

Knowledgebase ID: 002004 **Version number:** 4
Metadata type: Data element

Definition:	The country in which the person was born.
Context:	Country of birth is important in the study of access to services by different population sub-groups. Country of birth is the most easily collected and consistently reported of a range of possible data items that may indicate cultural or language diversity. Country of birth may be used in conjunction with other data elements such as Period of residence in Australia, etc., to derive more sophisticated measures of access to (or need for) services by different population sub-groups.

Relational and representational attributes

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

Data domain:	Standard Australian Classification of Countries 1998 (SACC). Australian Bureau of Statistics Cat. no. 1269.0 Reference through: < http://www.abs.gov.au/Ausstats/abs@.nsf/StatsLibrary > Select 'ABS classifications'.
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Guide for use: The Standard Australian Classification of Countries 1998 (SACC) is a four-digit, three-level hierarchical structure specifying major group, minor group and country.

A country, even if it comprises other discrete political entities such as 'states', is treated as a single unit for all data domain purposes. Parts of a political entity are not included in different groups. Thus, Hawaii is included in Northern America (as part of the identified country United States of America), despite being geographically close to and having similar social and cultural characteristics as the units classified to Polynesia.

Verification rules: **NHDD specific:**
DSS – Health care client identification:
County of birth for newborn babies should be 'Australia'.

Collection methods: Note that the Standard Australian Classification of Countries (SACC) is mappable to but not identical to Australian Standard Classification of Countries for Social Statistics (ASCCSS).

Some data collections ask respondents to specify their country of birth. In others, a pre-determined set of countries is specified as part of the question, usually accompanied by an 'other (please specify)' category. Recommended questions are:

In which country were you/was the person/was (name) born?

Australia
Other (please specify)

Alternatively, a list of countries may be used based on, for example, common Census responses.

In which country were you/was the person/was (name) born?

Australia

England

New Zealand

Italy

Viet Nam

Scotland

Greece

Germany

Philippines

India

Netherlands

Other (please specify)

In either case coding of data should conform to the SACC.

Sometimes respondents are simply asked to specify whether they were born in either 'English speaking' or 'non-English speaking' countries but this question is of limited use and this method of collection is not recommended.

Related metadata: Supersedes previous data element Country of birth, version 3.

Information model link: NHIM Demographic characteristic

Data set specifications:	Start date	End date
NMDS – Admitted patient care	01/07/2004	
NMDS – Admitted patient mental health care	01/07/2004	
NMDS – Perinatal	01/07/2004	
NMDS – Community mental health care	01/07/2004	
NMDS – Admitted patient palliative care	01/07/2004	
NMDS – Alcohol and other drug treatment services	01/07/2004	
NMDS – Non-admitted patient Emergency Department care	01/07/2004	
NMDS – Residential mental health care	01/07/2004	
DSS – Acute coronary syndrome (clinical)	04/06/2004	
DSS – Cardiovascular disease (clinical)	02/09/2003	
DSS – Health care client identification	02/09/2003	

Administrative attributes

Admin. status: CURRENT **Effective Date:** 02/09/2003

Source organisation: Australian Bureau of Statistics.
Health Data Standards Committee.
National Community Services Data Committee.

Source document: Australian Bureau of Statistics 1998. *Standard Australian Classification of*

Countries 1998 (SACC). Cat. no. 1269.0. Canberra: ABS.

Reference through:

<<http://www.abs.gov.au/Ausstats/abs@.nsf/StatsLibrary>>

Registration authority:

National Health Information Group.

National Community Services Information Management Group.

Steward:

Comments:

This metadata item is common to both the *National Health Data Dictionary* and the *National Community Services Data Dictionary*.

This data element is consistent with that used in the Australian Census of Population and Housing and is recommended for use whenever there is a requirement for comparison with Census data.

The Standard Australian Classification of Countries (SACC) supersedes the Australian Standard Classification of Countries for Social Statistics (ASCCSS).

Date of birth

Identifying and definitional attributes

Knowledgebase ID: 002005 **Version number:** 5
Metadata type: Data element

Definition:	The date of birth of the person.
Context:	Required for a range of clinical and administrative purposes. Date of birth enables derivation of age for use in demographic analyses, assists in the unique identification of clients if other identifying information is missing or in question, and may be required for the derivation of other data elements (e.g. Diagnosis related group for admitted patients).

Relational and representational attributes

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

Data domain:	Valid date.
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Guide for use: If date of birth is not known or cannot be obtained, provision should be made to collect or estimate age. Collected or estimated age would usually be in years for adults, and to the nearest 3 months (or less) for children aged less than 2 years. Additionally, an estimated date flag should be reported in conjunction with all estimated dates of birth.

For data collections concerned with children's services, it is suggested that the estimated Date of birth of children aged under 2 years should be reported to the nearest 3-month period, i.e. 0101, 0104, 0107, 0110 of the estimated year of birth. For example, a child who is thought to be aged 18 months in October of one year would have his/her estimated Date of birth reported as 0104 of the previous year. Again, an estimated date flag should be reported in conjunction with all estimated dates of birth.

Verification rules:

Collection methods: Information on Date of birth can be collected using the one question:
 What is your/(the person's) date of birth?
 In self-reported data collections, it is recommended that the following response format is used:
 Date of birth: __ / __ / ____
 This enables easy conversion to the preferred representational layout (DDMMYYYY).

Estimated dates of birth should be identified by an appropriate estimated date flag to prevent inappropriate use of Date of birth data for record identification and/or the derivation of other data elements that require accurate date of birth information.

NHDD specific:
 NMDS – Perinatal:
 Data collection systems must be able to differentiate between the date of birth of the mother and the baby(s). This is important in the Perinatal

data collection as the date of birth of the baby is used to determine the antenatal length of stay and the postnatal length of stay.

Related metadata: Supersedes previous data element Date of birth, version 4.
Is used in the derivation of Diagnosis related group, version 1.
Is qualified by Estimated date flag, version 1.
Is used in the derivation of Length of stay (antenatal), version 1.
Is used in the derivation of Length of stay (postnatal), version 1.

Information model link: NHIM Demographic characteristic

Data set specifications:	Start date	End date
NMDS – Admitted patient care	01/07/2004	
NMDS – Admitted patient mental health care	01/07/2004	
NMDS – Admitted patient palliative care	01/07/2004	
NMDS – Alcohol and other drug treatment services	01/07/2004	
NMDS – Community mental health care	01/07/2004	
NMDS – Health labour force	01/07/2004	
NMDS – Non-admitted patient Emergency Department care	01/07/2004	
NMDS – Perinatal	01/07/2004	
NMDS – Residential mental health care	01/07/2004	
DSS – Acute coronary syndrome (clinical)	04/06/2004	
DSS – Cancer (clinical)	04/06/2004	
DSS – Cardiovascular disease (clinical)	02/09/2003	
DSS – Diabetes (clinical)	02/09/2003	
DSS – Health care client identification	02/09/2003	

Administrative attributes

Admin. status: CURRENT **Effective Date:** 02/09/2003

Source organisation: Health Data Standards Committee.
National Community Services Data Committee.

Source document: AIHW: 2003. *National Health Data Dictionary*, Version 12.

Registration authority: National Health Information Group.
National Community Services Information Management Group.

Steward:

Comments: This metadata item is common to both the *National Health Data Dictionary* and the *National Community Services Data Dictionary*.
Privacy issues need to be taken account in asking persons their date of birth.
Wherever possible and wherever appropriate, Date of birth should be used rather than Age because the actual date of birth allows more precise calculation of age.

When Date of birth is estimated or default value, national health and community services collections typically use 0101 or 0107 or 3006 as the estimate or default for DDMM.

It is suggested that different rules for reporting data may apply when estimating the Date of birth of children aged under 2 years because of the rapid growth and development of children within this age group which means that a child's development can vary considerably over the course of a year. Thus, more specific reporting of estimated age is suggested.

NHDD specific:

DSS – Health care client identification:

Any new information collection systems should allow for 0000YYYY. (Refer to Standards Australia AS5017 – 2002 Health Care Client Identification).

DSS – Cardiovascular disease (clinical)

Age is an important non-modifiable risk factor for cardiovascular conditions. The prevalence of cardiovascular conditions increases dramatically with age. For example, more than 60% of people aged 75 and over had a cardiovascular condition in 1995 compared with less than 9% of those aged under 35. Aboriginal and Torres Strait Islander peoples are more likely to have cardiovascular conditions than other Australians across almost all age groups. For example, in the 25–44 age group, 23% of Indigenous Australians reported cardiovascular conditions compared with 16% among other Australians (Heart, Stroke and Vascular Diseases: Australian Facts 2001. AIHW).

Date of procedure

Identifying and definitional attributes

Knowledgebase ID: 000772 **Version number:** 1
Metadata type: Data element

Definition:	The date on which a procedure commenced during an inpatient episode of care.
Context:	Admitted patient care: Required to provide information on the timing of the procedure in relation to the episode of care

Relational and representational attributes

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

Data domain:	Valid date.
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Guide for use: Admitted patients:
Record date of procedure for all procedures undertaken during an episode of care in accordance with the current edition of ICD-10-AM.

Verification rules:

Collection methods: Right justified and zero filled (e.g. 1 May 2001 should read 01052001).
Date of procedure greater than or equal to Admission date.
Date of procedure less than or equal to Separation date.

Related metadata: Relates to the data element Procedure, version 5.

Information model link: NHIM Service provision event

Administrative attributes

Admin. status: CURRENT **Effective Date:** 01/07/2002

Source organisation: National Centre for Classification in Health.

Source document:

Registration authority: National Health Information Group.

Steward:

Comments: The National Centre for Classification in Health advises the Health Data Standards Committee of relevant changes to the ICD-10-AM.
Reference: Australian Institute of Health and Welfare (AIHW) 2000. *Australian hospital statistics 1998-1999*. AIHW cat. no. HSE 11. Canberra: AIHW (Health Services Series no. 15)

Diagnosis

Identifying and definitional attributes

Knowledgebase ID: 000398 **Version number:** 2
Metadata type: Data element concept

Definition:	A diagnosis is the decision reached, after assessment, of the nature and identity of the disease or condition of a patient or recipient of residential care (resident).
Context:	Health services: Diagnostic information provides the basis for analysis of health service usage, epidemiological studies and monitoring of specific disease entities.

Relational and representational attributes

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

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related metadata:

- Supersedes previous data element concept Diagnosis, version 1.
- Relates to the data element Additional diagnosis, version 5.
- Relates to the data element Complication of labour and delivery, version 2.
- Relates to the data element Complications of pregnancy, version 2.
- Relates to the data element Congenital malformations, version 2.
- Relates to the data element External cause – admitted patient, version 4.
- Relates to the data element Maternal medical conditions, version 2.
- Relates to the data element Neonatal morbidity, version 2.
- Relates to the data element Postpartum complication, version 2.
- Relates to the data element Principal diagnosis, version 4.

Information model link: NHIM Physical wellbeing

Administrative attributes

Admin. status: CURRENT **Effective Date:** 14/11/2003
Source organisation: Health Data Standards Committee.
Source document:

Registration authority: National Health Information Group.

Steward:

Comments: Classification systems which enable the allocation of a code to the diagnostic information:
International Classification of Diseases – Tenth Revision – Australian Modification (ICD-10-AM),
British Paediatric Association Classification of Diseases,
North America Nursing Diagnosis Association,
International Classification of Primary Care,
International Classification of Impairments, Disabilities and Handicaps,
International Classification of Functioning.

Diagnosis onset type

Identifying and definitional attributes

Knowledgebase ID:	000773	Version number:	1
Metadata type:	Data element		

Definition:	A qualifier for each coded diagnosis to indicate the onset and/or significance of the diagnosis to the episode of care.
Context:	Health services: Improved analysis of diagnostic information, especially in relation to patient safety and adverse event monitoring.

Relational and representational attributes

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

Data domain:	1	Primary condition
	2	Post-admit condition
	9	Unknown or uncertain

Guide for use:

Assign the relevant diagnosis type flag to all of the ICD-10-AM disease codes recorded in the hospital morbidity system. Specific guidelines for correct assignment of diagnosis flag type are in the current edition of ICD-10-AM Australian Coding Standards.

The following rules only apply to:

- diagnoses which meet the criteria in the Australian Coding Standards (ACS) 0001 Principal diagnosis and ACS 0002 Additional diagnoses or a specialty standard which requires the use of an additional code(s)
- hospital morbidity data
- 'episode of care' refers to hospital or day procedure episodes of care.

Code 1 Primary condition:

- a condition present on admission such as the presenting problem, a comorbidity, chronic disease or disease status. In the case of neonates, the condition(s) present at birth
- a previously existing condition not diagnosed until the current episode of care
- in delivered obstetric cases, all conditions which arise from the beginning of labour to the end of second stage.

Code 2 Post-admit condition:

- a condition which arises during the current episode of care and would not have been present on admission.

Code 9 Unknown or uncertain:

- a condition where the documentation does not support assignment to 1 or 2.

Explanatory notes:

The flag on external cause, place of occurrence and activity codes should match that of the corresponding injury or disease code.

The flag on morphology codes should match that on the corresponding neoplasm code.

Conditions meeting the criteria of principal diagnosis may, in some cases, have a flag of 2.

Verification rules:**Collection methods:**

A diagnosis onset type should be recorded and coded upon completion of an Episode of admitted patient care.

Related metadata:

Relates to the data element External cause – admitted patient, version 4.

Relates to the data element Principal diagnosis, version 4.

Relates to the data element Additional diagnosis, version 5.

Relates to the data element Place of occurrence of external cause of injury, version 6.

Relates to the data element Activity when injured, version 3.

Information model link:

NHIM Request for/entry into service event

Administrative attributes**Admin. status:**

CURRENT

Effective Date: 01/07/2002

Source organisation:

National Centre for Classification in Health.

Source document:**Registration authority:**

National Health Information Group.

Steward:**Comments:**