

Episode of admitted patient care

Identifying and definitional attributes

Knowledgebase ID: 000445 **Version number:** 2
Metadata type: Data element concept

Definition:	The period of admitted patient care between a formal or statistical admission and a formal or statistical separation, characterised by only one care type.
Context:	Admitted patient care.

Relational and representational attributes

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

Data domain:

Guide for use: This treatment and/or care provided to a patient during an episode of care can occur in hospital and/or in the person's home (for hospital-in-the-home patients).

Verification rules:

Collection methods:

Related metadata: Supersedes the previous data element concept Episode of care, version 1.
 Relates to the data element Separation date, version 5.
 Relates to the data element concept Admission date, version 4.
 Relates to the data element Care type, version 4.
 Relates to the data element concept Admission, version 3.
 Relates to the data element concept Admitted patient, version 3.
 Relates to the data element concept Separation, version 3.

Information model link: NHIM Service provision event

Administrative attributes

Admin. status: CURRENT **Effective Date:** 02/10/2003

Source organisation: Health Data Standards Committee.

Source document:

Registration authority: National Health Information Group.

Steward:

Comments:

Establishment number

Identifying and definitional attributes

Knowledgebase ID: 000377 **Version number:** 4
Metadata type: Data element

Definition:	An identifier for an establishment, unique within the state or territory.
Context:	All health services.

Relational and representational attributes

Representational class: Identification number **Format:** NNNNN
Data type: Numeric **Maximum field size:** 5

Data domain:	Valid establishment number.
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Guide for use:

Verification rules:

Collection methods:

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

Information model link: NHIM Organisation characteristic

Data set specifications:	Start date	End date
NMDS – Admitted patient care	01/07/2004	
DSS – Cancer (clinical)	04/06/2004	
DSS – Health care client identification	01/01/2003	

Administrative attributes

Admin. status: CURRENT **Effective Date:** 01/01/2003

Source organisation:

Source document:

Registration authority: National Health Information Group.

Steward:

Comments: Establishment number should be a unique code for the health care establishment used in that Australian state/territory or uniquely at a national level.

Establishment sector

Identifying and definitional attributes

Knowledgebase ID: 000379 **Version number:** 4
Metadata type: Data element

Definition: A section of the health care industry with which a health care establishment can identify.

Context:

Relational and representational attributes

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

Data domain:

1	Public
2	Private

Guide for use:

Alcohol and other drug treatment services NMDS:

In the Alcohol and other drug treatment services national minimum data set, this data element is used to differentiate between establishments run by the government sector (uses code 1) and establishments that receive some government funding but are run by the non-government sector (uses code 2).

Code 1 is to be used when the establishment:

- operates from the public accounts of a Commonwealth, state or territory government or is part of the executive, judicial or legislative arms of government;
- is part of the general government sector or is controlled by some part of the general government sector;
- provides government services free of charge or at nominal prices; and
- is financed mainly from taxation.

Code 2 is to be used in the AODTS NMDS only when the establishment:

- is not controlled by government;
- is directed by a group of officers, an executive committee or a similar body elected by a majority of members; and
- may be an income tax exempt charity.

Verification rules:

Collection methods:

Related metadata:

Relates to the data element concept Hospital, version 1.

Is a composite part of the data element Establishment identifier, version 4.

Supersedes the data element Establishment sector, version 2.

Information model link: NHIM Address element

NMDS – Admitted patient care 01/07/2004

DSS – Health care client identification 14/11/2003

Administrative attributes

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

Source organisation:

Source document:

Registration authority: National Health Information Group.

Steward:

Comments:

External cause — admitted patient

Identifying and definitional attributes

Knowledgebase ID: 000053 **Version number:** 4
Metadata type: Data element

Definition:	Environmental event, circumstance or condition as the cause of injury, poisoning and other adverse effect.
Context:	Institutional health care: Enables categorisation of injury and poisoning according to factors important for injury control. This information is necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research. It is also used as a quality of care indicator of adverse patient outcomes.

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: This code must be used in conjunction with an injury or poisoning codes and can be used with other disease codes. Admitted patients should be coded to the complete ICD-10-AM classification.

An external cause code should be sequenced following the related injury or poisoning code, or following the group of codes, if more than one injury or condition has resulted from this external cause. Provision should be made to record more than one external cause if appropriate. External cause codes in the range W00 to Y34, except Y06 and Y07 must be accompanied by a place of occurrence code (data element Place of occurrence of external cause).

External cause codes V01 to Y34 must be accompanied by an activity code (data element Activity when injured).

Verification rules: As a minimum requirement, the external cause codes must be listed in the ICD-10-AM classification.

Collection methods:

Related metadata: Supersedes previous data element External cause — admitted patient — ICD-9-CM code, version 3.

Is used in conjunction with the data element Place of occurrence of external cause, version 2.

Is used in conjunction with the data element Principal diagnosis, version 4.

Is used in conjunction with the data element Additional diagnosis, version 5.

Is used in conjunction with the data element Activity when injured, version 3.

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	01/07/1998	
NMDS – Injury Surveillance	01/07/1998	

Administrative attributes

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

Source organisation: Health Data Standards Committee.
National Centre for Classification in Health.
National Data Standards for Injury Surveillance Advisory Group.

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: An extended activity code is being developed in consultation with the National Injury Surveillance Unit, Flinders University, Adelaide.

Family name

Identifying and definitional attributes

Knowledgebase ID: 002007 **Version number:** 2
Metadata type: Data element

Definition:	That part of a name a person usually has in common with some other members of his/her family, as distinguished from his/her given names.
Context:	Administrative purposes and individual identification.

Relational and representational attributes

Data type: Alphanumeric **Maximum field size:** 40
Representational class: Text **Format:** AN(40)

Data domain:	Text.
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Guide for use: The agency or establishment should record the client's full 'Family name' on their information systems.

NCSDD specific:

In instances where there is uncertainty about which name to record for a person living in a remote Aboriginal or Torres Strait Islander community, Centrelink follows the practice of recording the Indigenous person's name as it is first provided to Centrelink. Or, where proof of identity is required, as the name is recorded on a majority of the higher point scoring documents that are produced as proof of identity.

Verification rules:

Collection methods:

This data element should be recorded for all clients.

Mixed case should be used.

Family name should be recorded in the format preferred by the person. The format should be the same as that written by the person on a (pre) registration form or in the same format as that printed on an identification card, such as Medicare card, to ensure consistent collection of name data.

It is acknowledged that some people use more than one family name (e.g. formal name, birth name, married/maiden name, tribal name) depending on the circumstances. Each name should be recorded against the appropriate name type (see Comments).

A person is able to change his or her name by usage in all states and Territories of Australia with the exception of Western Australia, where a person may only change his or her name under the Change of Name Act. Care should be taken when recording a change of name for a minor. Ideally, the name recorded for the minor should be known to both of his/her parents, so the minor's records can be retrieved and continuity of care maintained, regardless of which parent accompanies the minor to the agency or establishment.

A person should generally be registered using their preferred name as it is more likely to be used in common usage and on subsequent visits to the agency or establishment. The person's preferred name may in fact be

the name on their Medicare card. The Name type data element can be used to distinguish between the different types of names that may be used by the person. The following format may assist with data collection:

What is your family name? _____

Are you known by any other family names that you would like recorded? If so, what are they

Please indicate, for each name above, the 'type' of family name that is to be recorded:

(a) Medicare Card Name (if different to preferred name).

(b) Alias (any other name that you are known by). Whenever a person informs the agency or establishment of a change of family name (e.g. following marriage or divorce), the former name should be recorded as an alias name. A full history of names should be retained, e.g. 'Mary Georgina Smith' informs the hospital that she has been married and changed her family name to 'Jones'. Record 'Jones' as her preferred family name and record 'Smith' as an alias name.

Hyphenated family names:

Sometimes persons with hyphenated family names use only one of the two hyphenated names. It is useful to record each of the hyphenated names as an alias. If the person has a hyphenated family name, e.g. 'Wilson-Phillips' record 'Wilson-Phillips' in the preferred family name field and record 'Wilson' and 'Phillips' separately as alias family names.

Punctuation:

If special characters form part of the family name they should be included, e.g. hyphenated names should be entered with a hyphen.

Examples:

- hyphen, e.g. Wilson-Phillips

Do not leave a space before or after a hyphen, i.e. between the last letter of 'Wilson' and the hyphen, nor a space between the hyphen and the first letter of 'Phillips'.

- apostrophe, e.g. O'Brien, D'Agostino

Do not leave a space before or after the apostrophe, i.e. between the 'O' and the apostrophe, nor a space between the apostrophe and 'Brien'.

- full stop, e.g. St. John, St. George

Do not leave a space before a full stop, i.e. between 'St' and the full stop. Do leave a space between the full stop and 'John'.

- space, e.g. van der Humm, Le Brun, Mc Donald

If the health care client has recorded their family name as more than one word, displaying spaces in between the words, record their family name in the same way leaving one space between each word.

Registered unnamed newborn babies:

When registering a newborn, use the mother's family name as the baby's family name unless instructed otherwise by the mother. Record unnamed babies under the newborn Name Type.

Persons with only one name:

Some people do not have a family name and a given name, they have only one name by which they are known. If the person has only one name, record it in the 'Family name' field and leave the 'Given name' field blank.

Registering an unidentified health care client:

The default for unknown family name, should be unknown in all instances and the name recorded as an alias name. Don't create a 'fictitious' family name such as 'Doe' as this is an actual family name. When the person's name becomes known, record it as the preferred family name and do not overwrite the alias name of unknown.

Registering health care clients from disaster sites:

Persons treated from disaster sites should be recorded under the alias Name type. Local business rules should be developed for consistent recording of disaster site person details.

Care should be taken not to use identical dummy data (family name, given name, date of birth, sex) for two or more persons from a disaster site.

If the family name needs to be shortened:

If the length of the family name exceeds the length of the field, truncate the family name from the right (that is, dropping the final letters). Also, the last character of the name should be a hash (#) to identify that the name has been truncated.

Use of incomplete names or fictitious names:

Some health care facilities permit persons to use a pseudonym (fictitious or partial name) in lieu of their full or actual name. It is recommended that the person be asked to record both the pseudonym (Alias name) in addition to the person's Medicare card name.

Baby for adoption:

The word adoption should not be used as the family name, given name or alias for a newborn baby. A newborn baby that is for adoption should be registered in the same way that other newborn babies are registered. However, if a baby born in the hospital is subsequently adopted, and is admitted for treatment as a child, the baby is registered under their adopted (current) name, and the record should not be linked to the birth record. This should be the current practice. Any old references to adoption in client registers (for names) should also be changed to unknown. Contact your state or territory adoption information service for further information.

Prefixes:

Where a family name contains a prefix, such as one to indicate that the person is a widow, this must be entered as part of the 'Family Name' field. When widowed, some Hungarian women add 'Ozvegy' (abbreviation is 'Ozy') before their married family name, e.g. 'Mrs Szabo' would become 'Mrs Ozy Szabo'. That is, 'Mrs Szabo' becomes an alias name and 'Mrs Ozy Szabo' becomes the preferred name.

Ethnic names:

The Centrelink publication, *Naming Systems for Ethnic Groups*, provides the correct coding for ethnic names.

Misspelled family name:

If the person's family name has been misspelled in error, update the family name with the correct spelling and record the misspelled family name as an alias name. Recording misspelled names is important for filing documents that may be issued with previous versions of the person's name. Discretion should be used regarding the degree of recording that is maintained.

Often people use a variety of names, including legal names,

married/maiden names, nicknames, assumed names, traditional names, etc. Even small differences in recording – such as the difference between MacIntosh and McIntosh – can make record linkage impossible. To minimise discrepancies in the recording and reporting of name information, agencies or establishments should ask the person for their full (formal) ‘Given name’ and ‘Family name’. These may be different from the name that the person may prefer the agency or establishment workers to use in personal dealings. Agencies or establishments may choose to separately record the preferred names that the person wishes to be used by agency or establishment workers. In some cultures it is traditional to state the family name first. To overcome discrepancies in recording/reporting that may arise as a result of this practice, agencies or establishments should always ask the person to specify their first given name and their family name or surname separately. These should then be recorded as ‘Given name’ and ‘Family name’ as appropriate, regardless of the order in which they may be traditionally given.

Related metadata: Supersedes the data element Family name, version 1.
Relates to the data element concept Name, version 1.

Information model link: NHIM Person characteristic

Data set specifications:	Start date	End date
DSS – Cancer (clinical)	04/06/2004	
DSS – Health care client identification	02/09/2003	

Administrative attributes

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

Source organisation: Australian Government Department of Health and Ageing.
Australian Institute of Health and Welfare.
Standards Australia.
Health Data Standards Committee.
National Community Services Data Committee.

Source document: Australian Government Department of Health and Ageing 1998, *Home and Community Care Data Dictionary* Version 1.0. Canberra: DHFS.
Australian Institute of Health and Welfare Australian Standard AS5017 – 2002 Health Care Client Identification. Sydney: Standards Australia.

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*.

NCSDD specific:

Selected letters of the family name in combination with selected letters of the 'Given name', 'Date of birth' and 'Sex', may be used for record linkage for statistical purposes only.

Name type is a metadata item in Australian Standard AS5017 – 2002 Health care client identification (Standards Australia 2002) and in the *National Health Data Dictionary, Version 12* (NHDC 2003). In both cases the Data domain refers to Code A Alias name; Code M Medicare card name; Code N Newborn name; and Code P Preferred name. A name type data element is being considered for inclusion in a future version of the *National Community Services Data Dictionary*.

Given name(s)

Identifying and definitional attributes

Knowledgebase ID: 002008 **Version number:** 2
Metadata type: Data element

Definition: The person's identifying name(s) within the family group or by which the person is socially identified.

Context: Administrative purposes and individual identification.

Relational and representational attributes

Data type: Alphanumeric **Maximum field size:** 40
Representational class: Text **Format:** AN(4)

Data domain: Text.

Guide for use: The agency or establishment should record the client's full given name(s) on their information systems.

NCSDD specific:

In instances where there is uncertainty about which name to record for a person living in a remote Aboriginal or Torres Strait Islander community, Centrelink follows the practice of recording the Indigenous person's name as it is first provided to Centrelink. Or, where proof of identity is required, as the name is recorded on a majority of the higher point scoring documents that are produced as proof of identity.

NHDD specific:

Health care establishments may record given names (first and other given names) in one field or several fields. This data element definition applies regardless of the format of data recording.

A full history of names is to be retained.

Verification rules:

Collection methods:

This data element should be recorded for all clients.

Given name(s) should be recorded in the format preferred by the person. The format should be the same as that written by the person on a (pre) registration form or in the same format as that printed on an identification card, such as Medicare card, to ensure consistent collection of name data.

It is acknowledged that some people use more than one given name (e.g. formal name, birth name, nick name or shortened name, or tribal name) depending on the circumstances. A person is able to change his or her name by usage in all states and Territories of Australia with the exception of Western Australia, where a person may only change his or her name under the Change of Name Act.

A person should generally be registered using their preferred name as it is more likely to be used in common usage and on subsequent visits to

the agency or establishment. The person's preferred name may in fact be their legal (or Medicare card) name. The Name type data element (see Comments) can be used to distinguish between the different types of names that may be used by the person.

The following format may assist with data collection:

What is the given name you would like to be known by?

Are you known by any other given names that you would like recorded?

If so, what are they

Please indicate the 'type' of given name that is to be recorded:

(a) Medicare card name (if different to preferred name).

(b) Alias (any other name that you are known by).

Whenever a person informs the agency or establishment of a change of given name (e.g. prefers to be known by their middle name), the former name should be recorded according to the appropriate name type. Do not delete or overwrite a previous given name, e.g. 'Mary Georgina Smith' informs the hospital that she prefers to be known as 'Georgina'. Record 'Georgina' as her preferred 'Given Name' and record 'Mary' as the Medicare card 'Given Name'.

e.g. The agency or establishment is informed that 'Baby of Louise Jones' has been named 'Mary Jones'. Retain 'Baby of Louise' as the newborn name and also record 'Mary' as the preferred 'Given name'.

Registering an unidentified health care client:

If the person is a health care client and her/his given name is not known record unknown in the 'Given Name' field and use alias name type.

When the person's name becomes known, add the actual name as preferred Name type (or other as appropriate). Do not delete or overwrite the alias name of unknown.

Use of first initial:

If the person's given name is not known, but the first letter (initial) of the given name is known, record the first letter in the preferred 'Given Name' field. Do not record a full stop following the initial.

Persons with only one name:

Some people do not have a family name and a given name: they have only one name by which they are known. If the person has only one name, record it in the 'Family name' field and leave the 'Given name' blank.

Multiple given names (middle, second, third etc. names):

All of the person's given names should be recorded in the 'Given name' field, leaving a space between each name.

Record complete information:

If the person has many given names and all of them cannot fit in the field, record as many names in full as possible, in preference to recording initials.

Shortened or alternate first given name:

If the person uses a shortened version or an alternate version of their first given name, record their preferred name, the actual name as their Medicare card name and any alternative versions as alias names as appropriate.

e.g. The person's given name is Jennifer but she prefers to be called Jenny. Record 'Jenny' as the preferred 'Given name' and 'Jennifer' as her Medicare card name.

e.g. The person's given name is 'Giovanni' but he prefers to be called 'John'.

Record 'John' as the preferred 'Given name' and 'Giovanni' as the Medicare card name.

Punctuation:

If special characters form part of the given names they shall be included, e.g. hyphenated names shall be entered with the hyphen.

- Hyphen e.g. Anne-Maree, Mary-Jane

Do not leave a space before or after the hyphen, i.e. between last letter of 'Anne' and the hyphen, nor a space between the hyphen and the first letter of 'Maree'.

- Spaces e.g. Jean Claude

If the person has recorded their given name as more than one word, displaying spaces in between the words, record their given names in data collection systems in the same way.

e.g. Oscar Peter, Wendy Hilda

Leave a single space between the person's first name and each of their middle names.

Registering an unnamed newborn baby:

An unnamed (newborn) baby is to be registered using the mother's given name in conjunction with the prefix 'Baby of'. For example, if the baby's mother's given name is Fiona, then record 'Baby of Fiona' in the preferred 'Given name' field for the baby. This name is recorded under the newborn Name type. If a name is subsequently given, record the new name as the preferred given name and retain the newborn name.

Registering unnamed multiple births:

An unnamed (newborn) baby from a multiple birth should use their mother's given name plus a reference to the multiple birth. For example, if the baby's mother's given name is 'Fiona' and a set of twins is to be registered, then record 'Twin 1 of Fiona' in the 'Given name' field for the first born baby, and 'Twin 2 of Fiona' in the 'Given name' field of the second born baby. Arabic numbers (1, 2, 3 ...) are used, not Roman Numerals (I, II, III ...).

In the case of triplets or other multiple births the same logic applies. The following terms should be used for recording multiple births:

- Twin
Use Twin i.e. Twin 1 of Fiona
- Triplet
Use Trip i.e. Trip 1 of Fiona
- Quadruplet
Use Quad i.e. Quad 1 of Fiona
- Quintuplet
Use Quin i.e. Quin 1 of Fiona
- Sextuplet
Use Sext i.e. Sext 1 of Fiona

- Septuplet

Use Sept i.e. Sept 1 of Fiona.

These names should be recorded under the newborn Name type. When the babies are named, the actual names should be recorded as the preferred name. The newborn name is retained.

Aboriginal/Torres Strait Islander names not for continued use:

For cultural reasons, an Aboriginal or Torres Strait Islander may advise an agency or establishment that they are no longer using the given name that they had previously registered and are now using an alternative current name.

Record their current name as the preferred 'Given name' and record their previous used given name as an alias name.

Ethnic names:

The Centrelink *Naming Systems for Ethnic Groups* publication provides the correct coding for ethnic names. Refer to Ethnic Names Condensed Guide for summary information.

Misspelled given names:

If the person's given name has been misspelled in error, update the Given name field with the correct spelling and record the misspelled given name as an Alias name. Recording misspelled names is important for filing documents that may be issued with previous versions of the client's name. Discretion should be used regarding the degree of recording that is maintained.

Often people use a variety of names, including legal names, married/maiden names, nicknames, assumed names, traditional names, etc. Even small differences in recording – such as the difference between Thomas and Tom – can make record linkage impossible. To minimise discrepancies in the recording and reporting of name information, agencies or establishments should ask the person for their full (formal) Given name and Family name. These may be different from the name that the person may prefer the agency or establishment workers to use in personal dealings. Agencies or establishments may choose to separately record the preferred name that the person wishes to be used by agency or establishment workers. In some cultures it is traditional to state the family name first. To overcome discrepancies in recording/reporting that may arise as a result of this practice, agencies or establishments should always ask the person to specify their first given name and their family or surname separately. These should then be recorded as Given name and Family name as appropriate, regardless of the order in which they may be traditionally given.

Related metadata:

Supersedes the previous data element Given name(s), version 1.

Relates to the data element concept Name, version 1.

Information model link:

NHIM Person characteristic

Data set specifications:

DSS – Cancer (clinical)

Start date

End date

04/06/2004

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. Standards Australia. Health Data Standards Committee. National Community Services Data Committee.		
Source document:	Australian Government Department of Health and Ageing 1998, <i>Home and Community Care Data Dictionary</i> Version 1.0. Canberra. Standards Australia 2002. Australian Standard AS5017 – 2002 Health Care Client Identification. Sydney: Standards Australia.		
Registration authority:	National Health Information Group. National Community Services Information Management Group.		
Steward:			
Comments:	This metadata item is common to both the <i>National Health Data Dictionary</i> and the <i>National Community Services Data Dictionary</i> . NCSDD specific: Selected letters of the Given name in combination with selected letters of the Family name, Date of birth and Sex may be used for record linkage for statistical purposes only (see data concept Record linkage). Name type is a metadata item in Australian Standard AS5017 – 2002 Health care client identification (Standards Australia 2002) and in the <i>National Health Data Dictionary</i> Version 12 (NHDC 2003). In both cases the Data domain refers to Code A Alias name; Code M Medicare card name; Code N Newborn name; and Code P Preferred name. A name type data element is being considered for inclusion in a future version of the <i>National Community Services Data Dictionary</i> .		

Indicator procedure

Identifying and definitional attributes

Knowledgebase ID: 000073 **Version number:** 3
Metadata type: Data element

Definition: An indicator procedure is a procedure which is of high volume, and is often associated with long waiting periods.

Context: Waiting list statistics for indicator procedures give a specific indication of performance in particular areas of elective care provision.

It is not always possible to code all elective surgery procedures at the time of addition to the waiting list. Reasons for this include that the surgeon may be uncertain of the exact procedure to be performed, and that the large number of procedures possible and lack of consistent nomenclature would make coding errors likely. Furthermore, the increase in workload for clerical staff may not be acceptable. However, a relatively small number of procedures account for the bulk of the elective surgery workload. Therefore, a list of common procedures with a tendency to long waiting times is useful.

Waiting time statistics by procedure are useful to patients and referring doctors. In addition, waiting time data by procedure assists in planning and resource allocation, audit and performance monitoring.

Relational and representational attributes

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

Data domain:

01	Cataract extraction
02	Cholecystectomy
03	Coronary artery bypass graft
04	Cystoscopy
05	Haemorrhoidectomy
06	Hysterectomy
08	Inguinal herniorrhaphy
08	Myringoplasty
09	Myringotomy
10	Prostatectomy
11	Septoplasty
12	Tonsillectomy
13	Total hip replacement
14	Total knee replacement
15	Varicose veins stripping and ligation
16	Not applicable

Guide for use:	These procedure terms are defined by the ICD-10-AM codes which are listed in comments below. Where a patient is awaiting more than one indicator procedure, all codes should be listed. This is because the intention is to count procedures rather than patients in this instance. These are planned procedures for the waiting list, not what is actually performed during hospitalisation.
Verification rules:	Zero filled, right justified.
Collection methods:	
Related metadata:	Supersedes previous data element Indicator procedure – ICD-9-CM code, version 2. Supplements the data element Waiting list category, version 3. Is used in conjunction with the data element Procedure, version 5.
Information model link:	NHIM Service provision event

Data set specifications:	Start date	End date
NMDS – Elective surgery waiting times	01/07/2002	

Administrative attributes

Admin. status:	CURRENT	Effective Date:	01/07/1997
Source organisation:	Health Data Standards Committee.		
Source document:	Current edition of <i>International Classification of Diseases – Tenth Revision – Australian Modification</i> . National Centre for Classification in Health, Sydney.		
Registration authority:	National Health Information Group.		
Steward:			
Comments:	<p>The list of indicator procedures may be reviewed from time to time. Some health authorities already code a larger number of waiting list procedures.</p> <p>The following is a list of ICD-10-AM codes, for the indicator procedures:</p> <p>Cataract extraction:</p> <p>42698-00 [195] 42702-00 [195] 42702-01 [195] 42698-01 [196] 42702-02 [196] 42702-03 [196] 42698-02 [197] 42702-04 [197] 42702-05 [197] 42698-03 [198] 42702-06 [198] 42702-07 [198] 42698-04 [199] 42702-08 [199] 42702-09 [199] 42731-01 [200] 42698-05 [200] 42702-10 [200] 42734-00 [201] 42788-00 [201] 42719-00 [201] 42731-00 [201] 42719-02 [201] 42791-02 [201] 42716-00 [202] 42702-11 [200] 42719-00 [201] 42722-00 [201]</p> <p>Cholecystectomy:</p> <p>30443-00 [965] 30454-01 [965] 30455-00 [965] 30445-00 [965] 30446-00 [965] 30448-00 [965] 30449-00 [965]</p> <p>Coronary artery bypass graft:</p> <p>38497-00 [672] 38497-01 [672] 39497-02 [672] 38497-03 [672] 38497-04 [673] 38497-05 [673] 38497-06 [673] 39497-07 [673] 38500-00 [674] 38503-00 [674] 38500-01 [675] 38503-01 [675] 38500-02 [676] 38503-02 [676] 38500-03 [677]</p>		

38503-03 [677] 38500-04 [678] 38503-04 [678] 90201-00 [679] 90201-01 [679]
90201-02 [679] 90201-03 [679]

Cystoscopy:

36812-00 [1088] 36812-01 [1088] 36836-00 [1097]

Haemorrhoidectomy:

32138-00 [949] 32132-00 [949] 32135-00 [949] 32135-01 [949]

Hysterectomy:

35653-00 [1268] 35653-01 [1268] 35653-02 [1268] 35653-03 [1268] 35661-00
[1268] 35670-00 [1268] 35667-00 [1268] 35664-00 [1268] 35657-00 [1269]
35750-00 [1269] 35756-00 [1269] 35673-00 [1269] 35673-01 [1269] 35753-00
[1269] 35753-01 [1269] 35756-01 [1269] 35756-02 [1269] 35667-01 [1269]
35664-01 [1269] 90450-00 [989] 90450-01 [989] 90450-02 [989]

Inguinal herniorrhaphy:

30614-03 [990] 30615-00 [997] 30609-03 [990] 30614-02 [990] 30609-02 [990]

Myringoplasty:

41527-00 [313] 41530-00 [313] 41533-01 [313] 41542-00 [315] 41635-10 [313]

Myringotomy:

41626-00 [309] 31626-01 [309] 41632-00 [309] 41632-01 [309]

Prostatectomy:

37203-00 [1165] 37203-01 [1165] 37203-02 [1165] 37207-00 [1166] 37207-01
[1166] 37200-00 [1166] 37200-01 [1166] 37203-05 [1166] 37203-06 [1166]
37200-03 [1167] 37200-04 [1167] 37209-00 [1167] 37200-05 [1167] 90407-00
[1168] 36839-03 [1162] 36869-01 [1162]

Septoplasty:

41672-02 [379] 41679-03 [379]

Tonsillectomy:

41789-00 [412] 41789-01 [412]

Total hip replacement:

49318-00 [1489] 49319-00 [1489] 49324-00 [1492] 49327-00 [1492] 49330-00
[1492] 49333-00 [1492] 49345-00 [1492]

Total knee replacement:

49518-00 [1518] 49519-00 [1518] 49521-00 [1519] 49521-01 [1519] 49521-02
[1519] 49521-03 [1519] 49524-00 [1519] 49524-01 [1519] 49527-00 [1524]
49530-00 [1523] 49530-01 [1523] 49533-00 [1523] 49554-00 [1523] 49534-00
[1519]

Varicose veins stripping and ligation:

32508-00 [727] 32508-01 [727] 32511-00 [727] 32504-01 [728] 32505-00 [728]
32514-00 [737]

Indigenous status

Identifying and definitional attributes

Knowledgebase ID:	002009	Version number:	5
Metadata type:	Data element		

Definition:	Indigenous status is a measure of whether a person identifies as being of Aboriginal or Torres Strait Islander origin. This is in accord with the first two of three components of the Commonwealth definition. See Comments for the Commonwealth definition.
Context:	Australia's Aboriginal and Torres Strait Islander peoples occupy a unique place in Australian society and culture. In the current climate of reconciliation, accurate and consistent statistics about Aboriginal and Torres Strait Islander peoples are needed in order to plan, promote and deliver essential services, to monitor changes in wellbeing and to account for government expenditure in this area. The purpose of this data element is to provide information about people who identify as being of Aboriginal or Torres Strait Islander origin. Agencies or establishments wishing to determine the eligibility of individuals for particular benefits, services or rights will need to make their own judgements about the suitability of the standard measure for these purposes, having regard to the specific eligibility criteria for the program concerned.

Relational and representational attributes

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

Data domain:	1	Aboriginal but not Torres Strait Islander origin
	2	Torres Strait Islander but not Aboriginal origin
	3	Both Aboriginal and Torres Strait Islander origin
	4	Neither Aboriginal nor Torres Strait Islander origin
	9	Not stated/inadequately described

Guide for use: This data element is based on the ABS Standard for Indigenous Status. For detailed advice on its use and application please refer to the ABS Website as indicated below under Source document.

The classification for 'Indigenous status' has a hierarchical structure comprising two levels. There are four categories at the detailed level of the classification which are grouped into two categories at the broad level. There is one supplementary category for 'not stated' responses. The classification is as follows:

Indigenous:

- Aboriginal but not Torres Strait Islander origin
- Torres Strait Islander but not Aboriginal origin
- Both Aboriginal and Torres Strait Islander origin

Non-Indigenous:

- Neither Aboriginal nor Torres Strait Islander origin

Not stated/ inadequately described:

This category is not to be available as a valid answer to the questions but is intended for use:

- primarily when importing data from other data collections that do not contain mappable data;
- where an answer was refused;
- where the question was not able to be asked prior to completion of assistance because the client was unable to communicate or a person who knows the client was not available.

Only in the last two situations may the tick boxes on the questionnaire be left blank.

Verification rules:

Collection methods:

The standard question for Indigenous Status is as follows:

[Are you] [Is the person] [Is (name)] of Aboriginal or Torres Strait Islander origin?

(For persons of both Aboriginal and Torres Strait Islander origin, mark both 'Yes' boxes.)

No..... €

Yes, Aboriginal..... €

Yes, Torres Strait Islander..... €

This question is recommended for self-enumerated or interview-based collections. It can also be used in circumstances where a close relative, friend, or another member of the household is answering on behalf of the subject.

When someone is not present, the person answering for them should be in a position to do so, i.e. this person must know well the person about whom the question is being asked and feel confident to provide accurate information about them. However, it is strongly recommended that this question be asked directly wherever possible.

This question must always be asked regardless of data collectors' perceptions based on appearance or other factors.

The Indigenous status question allows for more than one response. The procedure for coding multiple responses is as follows:

If the respondent marks 'No' and either 'Aboriginal' or 'Torres Strait Islander', then the response should be coded to either Aboriginal or Torres Strait Islander as indicated (i.e. disregard the 'No' response).

If the respondent marks both the 'Aboriginal' and 'Torres Strait Islander' boxes, then their response should be coded to 'Both Aboriginal and Torres Strait Islander origin'.

If the respondent marks all three boxes ('No', 'Aboriginal' and 'Torres Strait Islander'), then the response should be coded to 'Both Aboriginal and Torres Strait Islander origin' (i.e. disregard the 'No' response).

This approach may be problematical in some data collections, for example when data are collected by interview or using screen-based data capture systems. An additional response category:

Yes, both Aboriginal and Torres Strait Islander... €

May be included if this better suits the data collection practices of the agency or establishment concerned.

Related metadata: Supersedes previous data element Indigenous status, version 4.

Information model link: NHIM Social 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 – 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: Australian Bureau of Statistics.
Health Data Standards Committee.
National Community Services Data Committee.

Source document: The ABS standards for the collection of Indigenous status appear on the ABS website.
<<http://www.abs.gov.au/Ausstats/abs@.nsf/StatsLibrary>>.
Select: Other ABS Statistical Standards/Standards for Social, Labour and Demographic Variables/Demographic Variables/Cultural Diversity Variables/Indigenous Status.

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*.
The following definition, commonly known as ‘the Commonwealth Definition’, was given in a High Court judgement in the case of *Commonwealth v Tasmania* (1983) 46 ALR 625.
‘An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she lives’.

There are three components to the Commonwealth definition:

- descent;
- self-identification; and
- community acceptance.

In practice, it is not feasible to collect information on the community acceptance part of this definition in general purpose statistical and administrative collections and therefore standard questions on Indigenous status relate to descent and self-identification only.

Informal carer availability

Identifying and definitional attributes

Knowledgebase ID:	002003	Version number:	4
Metadata type:	Data element		

Definition:	<p>Whether someone, such as a family member, friend or neighbour, has been identified as providing regular and sustained informal care and assistance to the person requiring care.</p> <p>Carers include those people who receive a pension or benefit for their caring role but does not include paid or volunteer carers organised by formal services.</p>
Context:	<p>Ageing, disability and health.</p> <p>Recent years have witnessed a growing recognition of the critical role that informal support networks play in caring for frail older people and people with disabilities within the community. Not only are informal carers responsible for maintaining people with often high levels of functional dependence within the community, but the absence of an informal carer is a significant risk factor contributing to institutionalisation. Increasing interest in the needs of carers and the role they play has prompted greater interest in collecting more reliable and detailed information about carers and the relationship between informal care and the provision of and need for formal services.</p>

Relational and representational attributes

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

Data domain:	1	Has a carer
	2	Has no carer
	9	Not stated / inadequately described

Guide for use:	<p>This data element is purely descriptive of a client's circumstances. It is not intended to reflect whether the carer is considered by the service provider to be capable of undertaking the caring role.</p> <p>In line with this, the expressed views of the client and/or their carer should be used as the basis for determining whether the client is recorded as having a carer or not.</p> <p>A carer is someone who provides a significant amount of care and/or assistance to the person on a regular and sustained basis. Excluded from the definition of carers are paid workers or volunteers organised by formal services (including paid staff in funded group houses).</p> <p>When asking a client about the availability of a carer, it is important for agencies or establishments to recognise that a carer does not always live with the person for whom they care. That is, a person providing significant care and assistance to the client does not have to live with the client in order to be called a carer.</p> <p>The availability of a carer should also be distinguished from living with someone else. Although in many instances a co-resident will also be a</p>
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carer, this is not necessarily the case. The data element Living arrangement is designed to record information about person(s) with whom the client may live.

Verification rules:

Collection methods:

Agencies or establishments and service providers may collect this item at the beginning of each service episode and also assess this information at subsequent assessments or re-assessments.

Some agencies, establishments/ providers may record this information historically so that they can track changes over time. Historical recording refers to the practice of maintaining a record of changes over time where each change is accompanied by the appropriate date.

Related metadata:

Supersedes previous data element Carer availability, version 3.

Information model link:

NHIM Request for/entry into service event

Data set specifications:

DSS – Cardiovascular disease (clinical)

Start date

End date

02/09/2003

Administrative attributes

Admin. status:

CURRENT

Effective Date:

02/09/2003

Source organisation:

Australian Institute of Health and Welfare.

Health Data Standards Committee.

National Community Services Data Committee.

Source document:

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 definition of 'Informal carer availability' is not the same as the ABS definition of 'Principal carer', used in the 1993 Disability, Ageing and Carers Survey and 'Primary carer' used in the 1998 survey. The ABS definitions require that the carer has or will provide care for a certain amount of time and that they provide certain types of care. This may not be appropriate for agencies or establishments wishing to obtain information about a person's carer regardless of the amount of time that care is for or the types of care provided. Information such as the amount of time for which care is provided can of course be collected separately but, if it were not needed, it would place a burden on service providers.

NHDD specific:

DSS Cardiovascular disease (clinical):

Informal carers are now present in 1 in 20 households in Australia (Schofield HL, Herrman HE, Bloch S, Howe A and Singh B. ANZ J PubH. 1997) and are acknowledged as having a very important role in

the care of stroke survivors (Stroke Australia Task Force. National Stroke Strategy. NSF; 1997) and in those with end-stage renal disease.

Absence of a carer may also preclude certain treatment approaches (for example, home dialysis for end-stage renal disease). Social isolation has also been shown to have a negative impact on prognosis in males with known coronary artery disease with several studies suggesting increased mortality rates in those living alone or with no confidant.

Intended place of birth

Identifying and definitional attributes

Knowledgebase ID: 000077 **Version number:** 2
Metadata type: Data element

Definition:	The intended place of birth at the onset of labour.
Context:	Perinatal care: Women who plan to give birth in birth centres or at home usually have different risk factors for outcome compared to those who plan to give birth in hospitals. Women who are transferred to hospital after the onset of labour have increased risks of intervention and adverse outcomes.

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:

Code 1	Hospital, excluding birth centre, includes for women who have elective caesarean sections.
Code 4	Home, should be restricted to the home of the woman or a relative or friend.
Code 8	Other, includes community (health) centres.

Verification rules:

Collection methods:

Related metadata:

- Supersedes the previous data element Intended place of birth, version 1.
- Is qualified by the data element Method of birth, version 2.
- Is qualified by the data element Onset of labour, version 2.
- Is qualified by the data element Actual place of birth, version 2.

Information model link: NHIM Planning event

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.

Inter-hospital contracted patient

Identifying and definitional attributes

Knowledgebase ID: 000079 **Version number:** 2
Metadata type: Derived data element

Definition:	An episode of care for an admitted patient whose treatment and/or care is provided under an arrangement between a hospital purchaser of hospital care (contracting hospital) and a provider of an admitted service (contracted hospital), and for which the activity is recorded by both hospitals.
Context:	Admitted patient care: To identify patients receiving services that have been contracted between hospitals. This item is used to eliminate potential double-counting of hospital activity in the analysis of patterns of health care delivery and funding and epidemiological studies.

Relational and representational attributes

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

Data domain:	1	Inter-hospital contracted patient from public sector hospital
	2	Inter-hospital contracted patient from private sector hospital
	3	Not contracted
	9	Not reported

Guide for use: A specific arrangement should apply (either written or verbal) whereby one hospital contracts with another hospital for the provision of specific services. The arrangement may be between any combination of hospital; for example, public to public, public to private, private to private, or private to public.

Verification rules:

Collection methods: All services provided at both the originating and destination hospitals should be recorded and reported by the originating hospital. The destination hospital should record the admission as an 'Inter-hospital contracted patient' so that these services can be identified in the various statistics produced about hospital activity. This data element will be derived as follows.

If Contract role = B (Hospital B, that is, the provider of the hospital service; contracted hospital), and Contract type = 2, 3, 4 or 5 (that is, a hospital, Hospital A) purchases the activity, rather than a health authority or other external purchaser, and admits the patient for all or part of the episode of care, and/or records the contracted activity within the patient's record for the episode of care). Then record a value of 1, if Hospital A is a public hospital or record a value of 2, if Hospital A is a private hospital.

Otherwise if the Contract role is not B, and/or the Contract type is not 2, 3, 4 or 5 record a value of 3.

Related metadata: Supersedes previous data element Inter-hospital same-day contracted patient, version 1.
 Is used in conjunction with the data element concept Contracted hospital care, version 1.
 Is derived from the data element Contract role, version 1.
 Is derived from the data element Contract type, version 1.

Information model link: NHIM Recipient role

Data set specifications:	Start date	End date
NMDS – Admitted patient care	01/07/2000	

Administrative attributes

Admin. status: CURRENT **Effective Date:** 01/07/2000

Source organisation: Health Data Standards Committee.

Source document:

Registration authority: National Health Information Group.

Steward:

Comments:

Labour force status

Identifying and definitional attributes

Knowledgebase ID: 002010 **Version number:** 3
Metadata type: Data element

Definition:	The self reported status the person currently has in being either in the labour force (employed/unemployed) or not in the labour force. The categories are determined by a person's status in relation to current economic activity (which is measured by their activities in relation to work in a specified reference period).
Context:	Labour force status is one indicator of the socio-economic status of a person and is a key element in assessing the circumstances and needs of individuals and families.

Relational and representational attributes

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

Data domain:	1 Employed
	2 Unemployed
	3 Not in the labour force
	9 Not stated/ inadequately described

Guide for use: Definitions for these categories are:

Code 1 Employed:

Persons aged 15 years and over who, during the reference week:

- (a) worked for one hour or more for pay, profit, commission or payment in kind in a job or business, or on a farm (comprising 'Employees', 'Employers' and 'Own Account Workers'); or
- (b) worked for one hour or more without pay in a family business or on a farm (i.e. 'Contributing Family Worker'); or
- (c) were 'Employees' who had a job but were not at work and were:
 - on paid leave
 - on leave without pay, for less than four weeks, up to the end of the reference week
 - stood down without pay because of bad weather or plant breakdown at their place of employment, for less than four weeks up to the end of the reference week
 - on strike or locked out
 - on workers' compensation and expected to be returning to their job; or

- receiving wages or salary while undertaking full-time study; or
- (d) were 'Employers', 'Own Account Workers' or 'Contributing Family Workers' who had a job, business or farm, but were not at work.

Code 2 Unemployed:

Unemployed persons are those aged 15 years and over who were not employed during the reference week, and:

- (a) had actively looked for full-time or part-time work at any time in the four weeks up to the end of the reference week. Were available for work in the reference week, or would have been available except for temporary illness (i.e. lasting for less than four weeks to the end of the reference week). Or were waiting to start a new job within four weeks from the end of the reference week and would have started in the reference week if the job had been available then; or
- (b) were waiting to be called back to a full-time or part-time job from which they had been stood down without pay for less than four weeks up to the end of the reference week (including the whole of the reference week) for reasons other than bad weather or plant breakdown.

Note: Actively looking for work includes writing, telephoning or applying in person to an employer for work. It also includes answering a newspaper advertisement for a job, checking factory or job placement agency notice boards, being registered with a job placement agency, checking or registering with any other employment agency, advertising or tendering for work or contacting friends or relatives.

Code 3 Not in the labour force:

Persons not in the labour force are those persons aged 15 years and over who, during the reference week, were not in the categories employed or unemployed, as defined. They include persons who were keeping house (unpaid), retired, voluntarily inactive, permanently unable to work, persons in institutions (hospitals, gaols, sanatoriums, etc.), trainee teachers, members of contemplative religious orders, and persons whose only activity during the reference week was jury service or unpaid voluntary work for a charitable organisation.

Verification rules:**Collection methods:**

For information about collection, refer to the ABS website:
<<http://www.abs.gov.au/>>

Related metadata:

Supersedes previous data element Labour force status, version 2.

Information model link:

NHIM Labour characteristic

Data set specifications:

DSS – Cardiovascular disease (clinical)

Start date

End date

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 1995. <i>Directory of Concepts and Standards for Social, Labour and Demographic Variables. Australia 1995</i> . Cat. no. 1361.30.00. Canberra: AGPS.		
Registration authority:	National Health Information Group. National Community Services Information Management Group.		
Steward:			
Comments:	This metadata item is common to both the <i>National Health Data Dictionary</i> and the <i>National Community Services Data Dictionary</i> .		

Main language other than English spoken at home

Identifying and definitional attributes

Knowledgebase ID:	002012	Version number:	3
Metadata type:	Data element		

Definition:	The language reported by a person as the main language other than English spoken by that person in his/her home (or most recent private residential setting occupied by the person) on a regular basis, to communicate with other residents of the home or setting and regular visitors.
Context:	<p>This data element is important in identifying those people most likely to suffer disadvantage in terms of their ability to access services due to language and/or cultural difficulties. In conjunction with Indigenous status, Proficiency in spoken English and Country of birth, this data element forms the minimum core set of cultural and language indicators recommended by the Australian Bureau of Statistics (ABS).</p> <p>Data on main language other than English spoken at home are regarded as an indicator of 'active' ethnicity and also as useful for the study of inter-generational language retention. The availability of such data may help providers of health and community services to effectively target the geographic areas or population groups that need those services. It may be used for the investigation and development of language services such as interpreter/translation services.</p>

Relational and representational attributes

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

Data domain:	Valid codes from ABS <i>Australian Standard Classification of Languages</i> , 1997, ABS Cat. No. 1267.0
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Guide for use:	<p>The Australian Standard Classification of Languages (ASCL) has a three-level hierarchical structure. The most detailed level of the classification consists of base units (languages) which are represented by four-digit codes. The second level of the classification comprises narrow groups of languages (the Narrow Group level), identified by the first two digits. The most general level of the classification consists of broad groups of languages (the Broad Group level) and is identified by the first digit. The classification includes Indigenous Australian languages and sign languages.</p> <p>For example, the Lithuanian language has a code of 3102. In this case 3 denotes that it is an Eastern European language, while 31 denotes that it is a Baltic language.</p> <p>The Pintupi Aboriginal language has a code of 8217. In this case 8 denotes that it is an Australian Indigenous language and 82 denotes that the language is Central Aboriginal.</p> <p>Language data may be output at the Broad Group level, Narrow Group level or base level of the classification. If necessary significant Languages within a Narrow Group can be presented separately while the remaining</p>
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languages in the Narrow Group are aggregated. The same principle can be adopted to highlight significant Narrow Groups within a Broad Group.

Note that the code 9900 should be used where language is Not stated/inadequately described. Code 9900 is not for use on primary collection forms. It is primarily for use in administrative collections when transferring data from data sets where the item has not been collected.

Persons not in private residential settings should respond for 'at home' as the most recent private residential setting in which that person has resided.

The reference in the title to 'at home' may cause offence to homeless persons and should be shortened to 'Main language other than English spoken' where applicable.

Verification rules:

Collection methods:

Data collected at the four-digit level (specific language) will provide more detailed information than that collected at the two-digit level. It is recommended that data be collected at the four-digit level however where this is not possible data should be collected at the two-digit level.

Recommended question:

Do you/Does the person/Does (name) speak a language other than English at home? (If more than one language, indicate the one that is spoken most often.)

No (English only) ____

Yes, Italian ____

Yes, Greek ____

Yes, Cantonese ____

Yes, Mandarin ____

Yes, Arabic ____

Yes, Vietnamese ____

Yes, German ____

Yes, Spanish

Yes, Tagalog (Filipino) ____

Yes, Other (please specify) _____

This list reflects the 9 most common languages spoken in Australia.

Languages may be added or deleted from the above short list to reflect characteristics of the population of interest.

Alternatively a tick box for 'English' and an 'Other – please specify' response category could be used.

Related metadata:

Supersedes previous data element Main language other than English spoken at home, version 1.

Information model link:

NHIM Social characteristic

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 1997. <i>Australian Standard Classification of Language (ASCL)</i> , 1997. Cat. no. 1267.0. Canberra: ABS. Reference through: < http://www.abs.gov.au/Ausstats/abs@.nsf/StatsLibrary >.		
	Australian Bureau of Statistics 1999. <i>Standards for Statistics on Cultural and Language Diversity</i> 1999. Cat no. 1289.0. Canberra: ABS. Reference through: < http://www.abs.gov.au/Ausstats/abs@.nsf/StatsLibrary >.		
	Select: Other ABS Statistical Standards.		
Registration authority:	National Health Information Group. National Community Services Information Management Group.		
Steward:			
Comments:	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.		

Main occupation of person

Identifying and definitional attributes

Knowledgebase ID: 002013 **Version number:** 3
Metadata type: Data element

Definition:	The occupation of a person describes the job in which the person is principally engaged. A job in any given establishment is a set of tasks designed to be performed by one individual in return for a wage or salary. An occupation is a set of jobs with similar sets of tasks. For persons with more than one job, the main job is the one in which the person works the most hours.
Context:	This data element may be useful in gaining an understanding of a clients situation and needs. For example, the occupation of a person with a disability may be directly relevant to the type of aids that they require.
	<p>NHDD specific:</p> <p>NMDS – Injury surveillance:</p> <p>There is considerable user demand for data on occupation-related injury and illness, including from Worksafe Australia and from industry, where unnecessary production costs are known in some areas and suspected to be related to others in work-related illness, injury and disability.</p>

Relational and representational attributes

Data type: Numeric **Maximum field size:** 7
Representational class: Code **Format:** NN(NN-NN)

Data domain:	Valid codes from the <i>Australian Standard Classification of Occupations</i> , Second edition 1997 (ABS Cat. no. 1220.0). Reference through: http://www.abs.gov.au/Ausstats/abs@.nsf/StatsLibrary . Select: ABS Classifications.
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Guide for use: This data element can be used to code the main occupation of persons involved in an event. Caution is advised in its use with regard to service providers as their activity as a service provider may not be their main occupation.

Verification rules:

Collection methods: This data element should only be collected from people whose Labour force status is employed.

Occupation is too complex and diverse an issue to fit neatly into any useable small group of categories. Therefore the Australian Bureau of Statistics (ABS) recommend that this data element be collected by using the following two open-ended questions:

Q1. In the main job held last week (or other recent reference period), what was your/the person's occupation?

Q2. What are the main tasks that you/the person usually perform(s) in that occupation?

The information gained from these two questions can then be used to select an appropriate code from the Australian Standard Classification of Occupations at any of the available levels (see Comments field below).

Accurate data are best achieved using computer assisted coding. A Computer Assisted Coding system is available from the ABS to assist in coding occupational data to Australian Standard Classification of Occupations codes.

Data coded at the four-digit and six-digit level will provide more detailed information than that collected at the higher levels and may be more useful. However, the level at which data are coded and reported will depend on the purpose of collecting this information.

If only one question is asked, question one should be used. The use of question one only, however, sometimes elicits responses which do not provide a clear occupation title and specification of tasks performed. As a result accurate coding at unit group or occupation level may not be possible.

While agencies are encouraged to use the recommended question described above, it is acknowledged that this is not always possible in practice. For example, where the data collection is a by-product of the provision of a health or community service, the information may be ascertained using different means. However, due to the complexities of the data element 'Occupation', this will result in inaccurate information. The recommended question should be used wherever possible.

Related metadata: Supersedes the previous data element Occupation of person, version 2.

Information model link: NHIM Labour characteristic

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 1997. *Australian Standard Classification of Occupations*, Second Edition, 1997, Cat. no. 1220.0. 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*.

The structure of the Australian Standard Classification of Occupations has five levels:

9 Major groups one-digit codes

35 Sub-major groups two-digit codes

For example:

Level	Code	Title
Major group	2	Professionals
Sub-major group	24	Education Professionals
Minor group	241	School Teachers
Unit group	2414	Special Education Teachers
Occupation	2414-13	Teacher of the Hearing Impaired

Main treatment type for alcohol and other drugs

Identifying and definitional attributes

Knowledgebase ID: 000639 **Version number:** 1
Metadata type: Data element

Definition:	The main activity determined at assessment by the treatment provider to treat the client's alcohol and/or drug problem for the principal drug of concern.
Context:	Alcohol and other drug treatment services. Information about treatment provided is of fundamental importance to service delivery and planning.

Relational and representational attributes

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

Data domain:	1	Withdrawal management (detoxification)
	2	Counselling
	3	Rehabilitation
	4	Pharmacotherapy
	5	Support and case management only
	6	Information and education only
	7	Assessment only
	8	Other

Guide for use:

To be completed at assessment or commencement of treatment.

The main treatment type is the principal activity as judged by the treatment provider that is necessary for the completion of the treatment plan for the principal drug of concern. The Main treatment type for alcohol and other drugs is the principal focus of a single treatment episode. Consequently, each treatment episode will only have one main treatment type.

For brief interventions, the main treatment type may apply to as few as one contact between the client and agency staff.

Code 1 Withdrawal management (detoxification), refers to any form of withdrawal management, including medicated and non-medicated, in any delivery setting.

Code 2 Counselling, refers to any method of individual or group counselling directed towards identified problems with alcohol and/or other drug use or dependency. This code excludes counselling activity that is part of a rehabilitation program as defined in code 3.

Code 3 Rehabilitation, refers to an intensive treatment program that integrates a range of services and therapeutic activities that may include counselling, behavioural treatment approaches, recreational activities, social and community living skills, group work and relapse prevention. Rehabilitation treatment can provide a high level of support (i.e. up to 24 hours a day) and tends towards a medium to longer-term duration.

Rehabilitation activities can occur in residential or non-residential settings. Counselling that is included within an overall rehabilitation program should be coded to code 3 for Rehabilitation, not to code 2 as a separate treatment episode for Counselling.

- Code 4 Pharmacotherapy, refers to pharmacotherapies that include those used as maintenance therapies (e.g. naltrexone, buprenorphine, and methadone treatment) and those used as relapse prevention. Use code 1 (withdrawal management) where a pharmacotherapy is used solely for withdrawal. Note collection exclusions: excludes treatment episodes for clients who are on an opioid pharmacotherapy maintenance program and are not receiving any other form of treatment.
- Code 5 Support and case management only, refers to when there is no treatment provided to the client other than support and case management (e.g. treatment provided through youth alcohol and drug outreach services). This choice only applies where support and case management treatment is recorded as individual client data and the treatment activity is not included in any other category.
- Code 6 Information and education only, refers to when there is no treatment provided to the client other than information and education. It is noted that, in general, service contacts would include a component of information and education.
- Code 7 Assessment only, refers to when there is no treatment provided to the client other than assessment. It is noted that, in general, service contacts would include an assessment component.

Verification rules:

Collection methods: Only one code to be selected.

Related metadata: Supersedes previous data element Occupation of person, version 2.
Relates to data element Other treatment type for alcohol and other drugs, version 1.

Information model link: NHIM Lifestyle characteristic

Data set specifications:	Start date	End date
NMDS – Alcohol and other drug treatment services	01/07/2001	

Administrative attributes

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

Source organisation: Intergovernmental Committee on Drugs National Minimum Data Set Working Group.

Source document:

Registration authority: National Health Information Group.

Steward:

Comments:

Marital status

Identifying and definitional attributes

Knowledgebase ID: 002014 **Version number:** 4
Metadata type: Data element

Definition:	A person's current relationship status in terms of a couple relationship or, for those not in a couple relationship, the existence of a current or previous registered marriage.
Context:	<p>Marital status is a core data element in a wide range of social, labour and demographic statistics. Its main purpose is analysis of the association of marital status with the need for and use of services, and for epidemiological analysis.</p> <p>Marital status also acts as an indicator for the level of support adult recipients of the welfare system have at home. The item is also used in comparisons of administrative data and population censuses and surveys.</p>

Relational and representational attributes

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

Data domain:	1	Never married
	2	Widowed
	3	Divorced
	4	Separated
	5	Married (registered and de facto)
	6	Not stated/inadequately described

Guide for use:

Refers to the current marital status of a person.

Code 2 Widowed, usually refers to registered marriages but when self reported may also refer to de facto marriages.

Code 4 Separated, usually refers to registered marriages but when self reported may also refer to de facto marriages.

Code 5 Married (registered and de facto), includes people who have been divorced or widowed but have since re-married, and should be generally accepted as applicable to all de facto couples, including of the same sex.

Code 6 Not stated/inadequately described, is not for use on primary collection forms. It is primarily for use in administrative collections when transferring data from data sets where the item has not been collected.

Verification rules:

Collection methods:	<p>This data element collects information on social marital status. The recommended question module is:</p> <p>Do you/Does the person usually live with a partner in a registered or de facto marriage?</p> <p>Yes, in a registered marriage</p> <p>Yes, in a defacto marriage</p> <p>No, never married</p> <p>No, separated</p> <p>No, divorced</p> <p>No, widowed</p> <p>It should be noted that information on marital status is collected differently by the ABS, using a set of questions. However, the question outlined above is suitable and mostly sufficient for use within the health and community services fields. See below (Source document) for information on how to access the ABS standards.</p> <p>While agencies are encouraged to use the recommended question described above, it is acknowledged that this is not always possible in practice. For example, where the data collection is a by-product of the provision of a health or community service, the information may be ascertained using different means. However, the recommended question should be used wherever practically possible.</p>
Related metadata:	Supersedes previous data element Marital status, version 3.
Information model link:	NHIM Social characteristic

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

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:	The ABS standards for the collection of Social and Registered marital status appear on the ABS website. Reference: < http://www.abs.gov.au/Ausstats/abs@.nsf/StatsLibrary >. Select: Other ABS Statistical Standards/Standards for Social, Labour and Demographic Variables/Demographic Variables.		
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*.

The ABS standards identify two concepts of marital status:

- Registered marital status – defined as whether a person has, or has had, a registered marriage;
- Social marital status – based on a person’s living arrangements (including de facto marriages), as reported by the person.

It is recommended that the social marital status concept be collected when information on social support/home arrangements is sought, whereas the registered marital status concept need only be collected where it is specifically required for the purposes of the collection.

While marital status is an important factor in assessing the type and extent of support needs, such as for the elderly living in the home environment, marital status does not adequately address the need for information about social support and living arrangements and other data elements need to be formulated to capture this information.

Maternal medical conditions

Identifying and definitional attributes

Knowledgebase ID: 000090 **Version number:** 2
Metadata type: Data element

Definition:	Pre-existing maternal diseases and conditions, and other diseases, illnesses or conditions arising during the current pregnancy, that are not directly attributable to pregnancy but may significantly affect care during the current pregnancy and/or pregnancy outcome.
Context:	Perinatal statistics: Maternal medical conditions may influence the course and outcome of the pregnancy and may result in antenatal admission to hospital and/or treatment that could have 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: Conditions should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM.

Collection methods:

Related metadata: Supersedes previous data element Maternal medical conditions – ICD-9-CM code, version 1.
Is used in conjunction with Complications of pregnancy, 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:

Mental health legal status

Identifying and definitional attributes

Knowledgebase ID: 000092 **Version number:** 5
Metadata type: Data element

Definition:	Whether a person is treated on an involuntary basis under the relevant State or territory mental health legislation, at any time during an episode of admitted patient care, an episode of residential care or treatment of a patient/client by a community based service during a reporting period. Involuntary patients are persons who are detained in hospital or compulsorily treated in the community under mental health legislation for the purpose of assessment or provision of appropriate treatment or care.
Context:	Mental health care: this data element is required to monitor trends in the use of compulsory treatment provisions under state and territory mental health legislation by Australian hospitals and community health care facilities, including 24-hour community-based residential services. For those hospitals and community mental health services which provide psychiatric treatment to involuntary patients, mental health legal status information is an essential data element within local record systems.

Relational and representational attributes

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

Data domain:	1 Involuntary patient
	2 Voluntary patient
	3 Not permitted to be reported under legislative arrangements in the jurisdiction

Guide for use:

Approval is required under the state or territory mental health legislation in order to detain patients for the provision of mental health care or for patients to be treated compulsorily in the community.

Code 1 Involuntary patient, should only be used by facilities which are approved for this purpose. While each state and territory mental health legislation differs in the number of categories of involuntary patient that are recognised, and the specific titles and legal conditions applying to each type, the legal status categories which provide for compulsory detention or compulsory treatment of the patient can be readily differentiated within each jurisdiction. These include special categories for forensic patients who are charged with or convicted of some form of criminal activity. Each state/territory health authority should identify which sections of their mental health legislation provide for detention or compulsory treatment of the patient and code these as involuntary status.

Code 3 Voluntary patient, to be used for reporting to the NMDS – Community mental health care, where applicable.

The mental health legal status of admitted patients treated within approved hospitals may change many times throughout the episode of care.

Patients may be admitted to hospital on an involuntary basis and subsequently be changed to voluntary status; some patients are admitted as voluntary but are transferred to involuntary status during the hospital stay. Multiple changes between voluntary and involuntary status during an episode of care in hospital or treatment in the community may occur depending on the patient's clinical condition and his/her capacity to consent to treatment.

Similarly the mental health legal status of residents treated within residential care services may change on multiple occasions throughout the episode of residential care or residential stay.

Verification rules:

Collection methods:

Admitted patients: to be reported as involuntary if the patient is involuntary at any time during the episode of care.

Residents in residential mental health care services: to be reported as involuntary if the resident is involuntary at any time during the episode of residential care.

Patients of ambulatory mental health care services: to be reported as involuntary if the patient is involuntary at the time a service contact.

Related metadata:

Supersedes previous data element Mental health legal status, version 4.

Information model link:

NHIM Legal characteristic

Data set specifications:

	<i>Start date</i>	<i>End date</i>
NMDS – Admitted patient care	01/07/2000	
NMDS – Admitted patient mental health care	01/07/2000	
NMDS – Community mental health care	01/07/2000	
NMDS – Residential mental health care	01/07/2004	

Administrative attributes

Admin. status: CURRENT **Effective Date:** 01/07/2000

Source organisation: Health Data Standards Committee.

Source document:

Registration authority: National Health Information Group.

Steward:

Comments:

Mother's original family name

Identifying and definitional attributes

Knowledgebase ID: 002015 **Version number:** 2
Metadata type: Data element

Definition: The original family name of the person's mother as reported by the person.

Context: May be used to confirm the identity of a person.

Relational and representational attributes

Data type: Alphanumeric **Maximum field size:** 40
Representational class: Text **Format:** AN(40)

Data domain: Text.

Guide for use: Mixed case should be used (rather than upper case only).

Verification rules:

Collection methods: See relevant paragraphs in the collection methods section of the data element Family name.

Related metadata: Supersedes the previous data element Mother's original family name, version 1.

Information model link: NHIM Person characteristic

Data set specifications: **Start date** **End date**
DSS – Health care client identification 02/09/2003

Administrative attributes

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

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

Source document: Australian Standard AS5017 – 2002 Health Care Client Identification.

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*.