National Health Data Dictionary

Version 12 Supplement

The Australian Institute of Health and Welfare is Australia's national health and welfare statistics and information agency. The Institute's mission is *better health and wellbeing for Australians through better health and welfare statistics and information.*

National Health Data Dictionary

Version 12 Supplement

Health Data Standards Committee
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Australian Institute of Health and Welfare

Board Chair
Hon. Peter Collins, AM, QC

Director
Dr Richard Madden

Foreword

The Australian Institute of Health and Welfare (AIHW) is pleased to produce this supplement to the twelfth version of the *National Health Data Dictionary* (NHDD), which is a vital tool for use in ensuring the quality of Australian health data.

In this time of constant change and with initiatives such as *HealthConnect* it is imperative that the health care community maintains the ability to standardise the meaning and representation of data used in the communication and analysis of health information. It is only through the cooperation and consensus of Australia's health sector that it is possible to produce in the Dictionary a set of core data specifications for use in all Australian health data collection settings. All Australian health departments, the Australian Bureau of Statistics, the Australian Institute of Health and Welfare, the National Centre for Classification in Health, the Australian Government Department of Veterans' Affairs, the Australian Private Hospitals Association, representatives of the private health insurance industry and the Health Insurance Commission cooperate in this endeavour.

Use of the Dictionary will help ensure that data elements are collected uniformly in all services and jurisdictions throughout Australia and thereby improve the quality of information for clinical communication, community discussion and public policy debate on health issues in Australia.

This supplement to Version 12 of the *National Health Data Dictionary* contains seventy new data items and sixty-six modified data items. Many of these items are included in new Data set specifications (DSS) designed to improve the quality of data used in the care of patients suffering from cancer and acute coronary syndromes. Data items from a new National Minimum Data Set (NMDS) for residential mental health care are also included in this publication. In addition, twenty-three modified data items reflect agreement between Australia's health and community services information authorities to integrate data standards across these sectors wherever possible.

Data elements in this edition continue to be presented in a format based on the ISO/IEC Standard 11179 (1994) *Specification and Standardization of Data Elements* – the international standard for defining data elements issued by the International Organization for Standardization and the International Electrotechnical Commission.

The AIHW Knowledgebase (Australian's Health, Community Services and Housing Assistance Metadata Registry) has been updated to incorporate this supplement to the twelfth version of the NHDD and is accessible via the following Internet page <http://www.aihw.gov.au/knowledgebase/index.html>.

The Knowledgebase is currently being redeveloped by the AIHW using a 2003 version of the ISO/IEC 11179 standard for metadata registries. The resulting Metadata Online Registry (METeOR) will be available in early 2005.

Thanks are due to Institute staff who have prepared the material for this supplement to the twelfth edition, and to all members of the Health Data Standards Committee who have overseen its preparation.

I urge all collectors of health-related data in Australia to use the Dictionary and so improve the quality of Australian health data.

Richard Madden

Director

Australian Institute of Health and Welfare

Preface

With the increasing use of electronic means of dissemination, the decision was taken to publish in paper form a full version of the *National Health Data Dictionary* only every two years.

This is the second time in which this publication contains only changes and additions to the previous version of the Data Dictionary—i.e. it only contains items that have been added, updated or revised since the publication of Version 12 NHDD. Data items that have not been modified since Version 12 can be found in the *National Health Data Dictionary* Version 12. The full NHDD Version 12 is available on the AIHW Knowledgebase and on CD-ROM. Electronic copies of the previous complete NHDD Version 12 can also be referenced from <http://www.aihw.gov.au/publications/hwi/nhdd12/index.html>. A CD-ROM amalgamating NHDD Version 12 and this supplement is also available.

Currently, the Knowledgebase is being redeveloped using the updated ISO/IEC 11179 standard (2003). The resulting Metadata Online Registry (METeOR) will be completed in early 2005 and will also provide guidelines for data developers.

The Institute welcomes your views on this publication and your suggestions for improving the content and dissemination of national health data standards. Please send your feedback by post or fax using the feedback form at the back of this publication or by email to <knowledgebase@aihw.gov.au>.

Contents

Introduction

The *National Health Data Dictionary* (NHDD) was first published as the *National Minimum Data Set—Institutional Health Care* in September 1989. In March 1993 the *National Health Data Dictionary—Institutional Health Care* (Version 2.0) was published. Since the establishment of the first National Health Information Agreement in June 1993 there have been many changes in the development and management of national health information resulting in the expansion of both the scope and content of subsequent versions of the *National Health Data Dictionary*. The National Health Information Agreement was renewed in May 1998 for a further five years and again in May 2004.

Under the National Health Information Agreement, the *National Health Data Dictionary* is the authoritative source of health data definitions used in Australia where national consistency is required. In 2000, the Australian Health Ministers' Advisory Council (AHMAC) also endorsed the Data Dictionary as the source of data standards to support Australia's initiatives in electronic capture and exchange of health information.

The Dictionary is designed to improve the comparability of data across the health field. It is also designed to make data collection activities more efficient by reducing duplication of effort in the field, and more effective by ensuring that information to be collected is appropriate to its purpose.

The objectives of the *National Health Data Dictionary* are to:

–   establish a core set of uniform definitions relating to the full range of health services and a range of population parameters (including health status and determinants);

–   promote uniformity, availability, reliability, validity, consistency and completeness in the data;

–   accord with nationally and internationally agreed protocols and standards, wherever possible; and

–   promote the national standard definitions by being readily available to all individuals and organisations involved in the generation, use and/or development of health and health services information.

The Health Data Standards Committee is responsible for coordinating the development and revision of the *National Health Data Dictionary*.

The Health Data Standards Committee (HDSC)

The Health Data Standards Committee is a standing committee of the National Health Information Group (NHIG)—a body established by the Australian Health Ministers' Advisory Council (AHMAC) with responsibility to oversee implementation of the National Health Information Agreement. All data element definitions to be included in the *National Health Data Dictionary* require endorsement by the NHIG.

The primary role of the Health Data Standards Committee is to assess data definitions proposed for inclusion in the *National Health Data Dictionary* and to make recommendations to the NHIG on revisions and additions to each successive version of the Dictionary. In particular, the Committee's role is to ensure that the *National Health Data Dictionary* definitions comply with endorsed standards for the definition of data elements and that all data definitions being considered for the Dictionary have undergone sufficient national consultation with recognised experts and stakeholders in the relevant field.

The rules applied to each data element definition are designed to ensure that each definition is clear, concise and comprehensive, and provides sufficient information to ensure that all those who collect, provide, analyse and use the data, understand its meaning.

All definitions in the *National Health Data Dictionary* are presented in a format that is described in more detail at Appendix B.

The Health Data Standards Committee comprises representatives of:

– the Australian Government Department of Health and Ageing

– each state and territory government health authority

– the Australian Bureau of Statistics

– the Australian Institute of Health and Welfare

– the Australian Private Hospitals' Association

– the private health insurance industry

– the Australian Government Department of Veterans' Affairs

– the National Centre for Classification in Health

– the Health Insurance Commission

– the Information and Communications Technology Standards Committee (ICTSC)

– Standards Australia IT-14 Health Informatics Committee

– a representative from the Consumer's Health Forum Australia

– Australian clinicians.

The NHIG appoints the Chair of the Health Data Standards Committee (HDSC), currently Dr Ching Choi of the Australian Institute of Health and Welfare.

A list of Committee members and their contact details is provided at Appendix A.

The Health Data Standards Committee does not normally develop data definitions directly. Rather, it provides a channel through which standards emerging from nationally focused data development work are documented and endorsed by the NHIG. This facilitates implementation in national data collections and allows wider availability to stakeholders in the national health information arena. The range and relevance of the data definitions included in the *National Health Data Dictionary* are dependent, to a significant extent, on the material submitted to the Health Data Standards Committee by the expert working groups that are actively developing data in the health field.

More information about the Health Data Standards Committee and its processes is available from the HDSC Secretariat (see Secretariat contact details at the end of this section).

The AIHW Knowledgebase—Australia's Health, Community Services and Housing Assistance Metadata Registry

The AIHW Knowledgebase—Australia's Health, Community Services and Housing Assistance Metadata Registry is an electronically accessible registry of national data definitions. The Knowledgebase was designed and created by the Australian Institute of Health and Welfare on behalf of the NHIG.

Organisations that have authority to create data definitions in the Knowledgebase are given the status of 'Registration Authority'. The organisation authorised to register *National Health Data Dictionary* data definitions in the Knowledgebase is the National Health Information

Group. The organisation authorised to register *National Community Services Data Dictionary* data definitions in the Knowledgebase is the National Community Services Information Management Group (NCSIMG). The organisation authorised to register *National Housing Assistance Data Dictionary* data definitions in the Knowledgebase is the National Housing Data Agreement Management Group (NHDAMG).

The Knowledgebase integrates and presents information about:

– the *National Health Data Dictionary*

– National Minimum Data Set agreements

– the National Health Information Model

– the National Community Services Information Model

– the *National Community Services Data Dictionary*

– the *National Housing Assistance Data Dictionary*.

The integrating features of the Knowledgebase enable information managers and policy developers to query and view information in ways not possible with traditional paper-based records, repositories, data dictionaries or manuals. It is envisaged that, over time, access to the *National Health Data Dictionary* will be primarily electronic—via the redeveloped Knowledgebase (i.e. the Metadata Online Registry or METeOR).

The Knowledgebase is an Internet application, accessible through any browser compatible with HTML version 3.2 or later. It has been written using Oracle's Webserver technology.

Note that the Knowledgebase contains the latest version of all metadata items and should be used when locating metadata items that have been modified since the publication of this supplement to the *National Health Data Dictionary*.

The Internet address for the Knowledgebase—Australia's Health and Community Services and Housing Assistance Metadata Registry is:

<http://www.aihw.gov.au/knowledgebase/>

The Metadata Online Registry—METeOR

The current nationally endorsed data standards for health, community services and housing assistance are electronically accessible via the AIHW Knowledgebase, and published through national data dictionaries. The structure of these metadata is based on the 1994 version of the ISO/IEC 11179 standard for the specification and standardisation of data elements.

The Knowledgebase is currently undergoing a redevelopment process so that data items can be represented using the new 2003 version of the ISO/IEC 11179 standard. The resulting system will be known as the Metadata Online Registry (METeOR) and will be available in early 2005.

This redevelopment project recognises the need to have a greater level of formalisation, and a greater degree of discipline in identifying and registering discrete components of a data element in a metadata registry.

The new METeOR system reflects significant progression of the work of the national data standards committees, and is a response to the issues and pressures that they encounter. It will also provide a structure that allows national metadata development to continue to grow and adapt to emerging needs of national electronic data exchange to support care provision, information systems development, and statistical reporting.

National Health Data Dictionary

All data definitions that are included in the latest version of the *National Health Data Dictionary* as well as all previous versions of those data definitions are available on the AIHW Knowledgebase.

Version 12 Supplement

This supplement contains only new data items or those that have been modified since the publication of *National Health Data Dictionary* Version 12 (2003). All data items, including those that have been superseded or rendered obsolete by new data items or new versions of data items are currently available on the Knowledgebase. The Internet address (URL) to access national health metadata via the Knowledgebase is: <http://www.aihw.gov.au/knowledgebase/indexkbhealth.html>.

Select '*National Health Data Dictionary* (NHDD)' from this page to get to the search page for the latest version of the Dictionary. An 'Advanced Search' facility is available from this page. Alternatively, data items can be displayed/selected by alphabetic character.

To reference the *National Health Data Dictionary* in its entirety, one must read both publications in conjunction Version 12 and Version 12 Supplement. Alternatively, a CD-ROM amalgamating NHDD V12 and this supplement are also available.

For completeness, descriptions of the content of all the National Minimum Data Sets (NMDS) have been included showing the changes to NMDSs, the data items added to NMDSs, new versions of data items within the NMDSs, and the retirement of obsolete data items from NMDSs. These NMDS modifications have been endorsed by both the Statistical Information Management Committee (SIMC) and the National Health Information Group (NHIG).

As in Version 12, data definitions are presented in a format based on the standard ISO/IEC 11179 (1994) *Specification and Standardization of Data Elements* – the international standard for defining data elements issued by the International Organization for Standardization and the International Electrotechnical Commission. This format is explained in detail at Appendix B.

International Classification of Diseases, Version 10, Australian Modification, 3rd Edition (ICD-10-AM)

The Health Data Standards Committee (HDSC) has endorsed that all references to ICD-10-AM in the version 12 Supplement to the *National Health Data Dictionary* are to the *third* edition of the ICD-10-AM implemented from 1 July 2002.

Using national data standards—compliance and consistency

The *National Health Data Dictionary* provides agreed national standard specifications for data elements. When data is exchanged between two parties or systems it must meet the requirements of the national standard. Data exchanged between two parties is considered:

a. **compliant** with the Dictionary when it meets ALL requirements of the national standards. All data supplied as part of a National Minimum Data Set (NMDS) must be **compliant**, i.e. all supplied data must exactly meet the specified requirements for the data elements.

b. **consistent** with the Dictionary only if:

- the definition of the data element is the same in the NHDD; and

- the Data type, Representation class, Format, Maximum field size, or Data Domains are different, but the data is still convertible to the national data element standard without loss of the meaning.

There may be instances where compliance with the Dictionary cannot be achieved, but where consistency with the Dictionary is sufficient to meet local requirements.

Examples are provided below using the permissible values for the Marital status data element.

The *National Health Data Dictionary* Data domain for the data element Marital status (Knowledgebase Identifier 000089) is:

1	Never married
2	Widowed
3	Divorced
4	Separated
5	Married (including de facto)
6	Not stated/inadequately described

Submitted data that uses only these coding categories, numbers and labels would be considered 'compliant with the *National Health Data Dictionary*'.

Examples of *National Health Data Dictionary* consistent and inconsistent values are:

NHDD consistent ☑		NHDD consistent ☑		NHDD inconsistent ☒	
s	Never married	1	Never married	s	Single
w	Widowed	2	Widowed	w	Widowed
d	Divorced	3	Divorced		
a	Separated	4	Separated	a	Separated or Divorced
m	Married (including de facto)	5	Married (excluding de facto)	m	Married
		6	De facto		
z	Not stated/inadequately described	9	Not stated/inadequately described		
Although the codes are not NHDD compliant they can be mapped (i.e. converted) directly to the NHDD codes. A data element using these permissible values could be considered 'NHDD consistent'.		Although codes 5 and 6 are not 'NHDD compliant', the data is still 'NHDD consistent'. Code 5 and code 6 data can be mapped to code 5 of the NHDD data domain.		'Single' is not the same as 'Never married' and may be misconstrued for persons who are divorced and now 'single' or for persons in a de facto relationship. Code 'a' cannot be mapped to the original data domain as it combines two different standard codes in one 'Married' does not include the 'de facto' which may lead to it being recorded under any of the other codes.	

Feedback

Readers are invited to comment on any aspect of the *National Health Data Dictionary* by copying, completing and returning the Feedback Form included at the back of this publication.

Comments and suggestions can also be provided electronically via the 'Kb Feedback' area on the Knowledgebase Internet page or alternatively, using the following email address.

Email: feedback@aihw.gov.au

Secretariat contact details

Further information about the *National Health Data Dictionary* and the Health Data Standards Committee can be obtained through the Health Data Standards Committee Secretariat at the Australian Institute of Health and Welfare.

HDSC Secretariat   Phone: (02) 6244 1123

Fax: (02) 6244 1111

Email: hdscsec@aihw.gov.au

Postal address: HDSC Secretariat

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GPO Box 570

Canberra ACT 2601

Summary of changes

National Minimum Data Sets

– **NMDS Admitted patient care** — modified
  - ➢ removal of data elements and data element concepts:
    – Establishment identifier
    – Number of leave periods
    – Region code
  - ➢ addition of existing data elements and data element concepts:
    – Establishment number
    – Establishment sector
    – Hospital boarder
    – Organ procurement — posthumous
  - ➢ modifications to existing data elements and data element concepts:
    – Activity when injured
    – Australian state/territory identifier
    – Inter-hospital contracted patient
    – Place of occurrence of external cause of injury

– **NMDS Alcohol and other drug treatment services** — modified
  - ➢ modifications to existing data elements and data element concepts in the NMDS:
    – Establishment sector
    – Main treatment type for alcohol and other drugs
    – Other treatment type for alcohol and other drugs
    – Principal drug of concern
    – Other drug of concern
    – Reason for cessation of treatment episode for alcohol and other drugs
    – 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
  - ➢ removal of data elements and data element concepts in the NMDS:
    – Number of service contacts within a treatment episode for alcohol and other drugs
    – Service contact

– **NMDS Community mental health establishments —** modified
  ➢ addition of new data element to NMDS:
    – Specialised mental health service setting
  ➢ addition of new data element concept to NMDS:
    – Specialised mental health service

– **NMDS Emergency Department waiting times —** deleted

– **NMDS Perinatal —** modified
  ➢ removal of data element from the NMDS:
    – First day of last menstrual period

– **NMDS Residential mental health care —** New
  ➢ addition of new data elements to NMDS:
    – Episode of residential care end date
    – Episode of residential care end mode
    – Episode of residential care start date
    – Episode of residential care start mode
    – Leave days from residential care
    – Referral from specialised mental health residential care
    – Residential stay start date
  ➢ addition of new data element concepts to NMDS:
    – Episode of residential care
    – Episode of residential care end
    – Episode of residential care start
    – Resident
    – Residential mental health service
    – Residential stay
    – Specialised mental health service
  ➢ addition of existing data elements and data element concepts to the NMDS:
    – Area of usual residence
    – Establishment identifier
    – Establishment number
    – Region code
  ➢ modifications to existing data elements and data element concepts in the NMDS:
    – Additional diagnosis
    – Australian state/territory identifier

–   Country of birth

–   Date of birth

–   Diagnosis

–   Establishment sector

–   Indigenous status

–   Marital status

–   Mental health legal status

–   Person identifier

–   Principal diagnosis

–   Sex

Data set specifications

DSS Acute coronary syndrome (clinical) — New

New non-mandatory core data set for acute coronary syndrome.

DSS Cancer (clinical) — New

New non-mandatory core data set for cancer.

Data elements and data element concepts

New in version 12 Supplement

Acute coronary syndrome (clinical) data set specification

—   Acute coronary syndrome procedure type

—   Acute coronary syndrome stratum

—   Angiotensin converting enzyme (ACE) inhibitors therapy status

—   Aspirin therapy status

—   Beta—blocker therapy status

—   Bleeding episode using TIMI criteria — status

—   Chest pain pattern category

—   Clinical evidence status

—   Clinical procedure timing status

—   Clopidogrel therapy status

—   Concurrent clinical condition — on presentation

—   Creatine kinase MB isoenzyme (CK-MB) — measured

—   Creatine kinase MB isoenzyme (CK-MB) —units

—   Creatine kinase MB isoenzyme (CK-MB) — upper limit of normal range

—   Date creatine kinase MB isoenzyme (CK-MB) — measured

— Date of first angioplasty balloon inflation or stenting
— Date of intravenous fibrinolytic therapy
— Date troponin measured
— Electrocardiogram (ECG) change — location
— Electrocardiogram (ECG) change — type
— Fibrinolytic drug used
— Fibrinolytic therapy status
— Functional stress test element
— Functional stress test ischaemic result
— Glycoprotein IIb/IIIa receptor antagonist status
— Heart rate
— Heart rhythm type
— Killip classification code
— Lipid-lowering therapy status
— Reason for readmission — Acute coronary syndrome
— Time creatine kinase MB isoenzyme (CK-MB) measured
— Time of first angioplasty balloon inflation or stenting
— Time of intravenous fibrinolytic therapy
— Time troponin measured
— Troponin assay type
— Troponin assay — upper limit of normal range
— Troponin measured

Address data items
— Address line
— Building/complex sub-unit number
— Building/complex sub-unit type — abbreviation
— Building/property name
— Floor/level number
— Floor/level type
— House/property number
— Lot/section number
— Postal delivery service number
— Postal delivery service type — abbreviation
— Street name
— Street suffix code
— Street type code

Cancer (clinical) Data Set Specification
— Cancer initial treatment — completion date
— Cancer initial treatment — starting date
— Cancer staging — M stage code
— Cancer staging — N stage code
— Cancer staging — T stage code
— Cancer staging — TNM stage grouping code
— Cancer treatment type
— Cancer treatment — target site
— Date of death
— Date of diagnosis of first recurrence
— Date of surgical treatment for cancer
— Histopathological grade
— Initial treatment episode for cancer
— Intention of treatment for cancer
— Most valid basis of diagnosis of cancer
— Oestrogen receptor assay status
— Outcome of initial treatment
— Progesterone receptor assay status
— Radiotherapy treatment type
— Received radiation dose
— Region of first recurrence
— Regional lymph nodes examined
— Regional lymph nodes positive
— Staging basis
— Staging scheme source
— Staging scheme source edition number
— Surgical treatment procedure for cancer
— Systemic therapy agent name

Cancer registries data items
— Degree of spread of cancer
— Most valid basis of diagnosis of cancer

Community mental health establishments NMDS
— Specialised mental health service setting

Residential mental health care NMDS

— Episode of residential care

— Episode of residential care end

— Episode of residential care end date

— Episode of residential care end mode

— Episode of residential care start

— Episode of residential care start date

— Episode of residential care start mode

— Leave days from residential care

— Referral from specialised mental health residential care

— Resident

— Residential mental health service

— Residential stay

— Residential stay start date

— Specialised mental health service

Specialist private sector rehabilitation care indicator

— Specialist private sector rehabilitation care indicator

Modified in version 12 Supplement

Address Data Items

— Address

  - new version number
  - modification to 'Definition' section
  - removed text in 'Context' section
  - modification to 'Guide for use' section
  - removed existing reference in 'Source document' section
  - modification to 'Comments' section

Amendments to the following data elements were made to correct errors that existed in Version 12 of the NHDD

— Actual place of birth

— Intended place of birth

— Previous pregnancies

Admitted patient care NMDS

— Activity when injured

  - new version number
  - added alphanumeric data type for admitted patients to 'Data type' section
  - added admitted patient format to 'Format' section

    - added maximum field size for admitted patients to 'Maximum field size' section

    - added admitted patient information to the 'Data domain' section

    - removed 'ICD-10-AM' text from the admitted patient information in the 'Guide for use' section

    - removed reference to external cause codes from the 'Verification rules' section

— Australian state/territory identifier

    - added information to the 'Guide for use' section further explaining the use of this data element in the admitted patient care NMDS

— Episode of admitted patient care

    - new version number

    - modified title from Episode care

— Inter-hospital contracted patient

    - modified option 3 in the 'Data domain' section

— Place of occurrence of external cause of injury

    - new version number

    - added alphanumeric data type for admitted patients to 'Data type' section

    - added admitted patient format to 'Format' section

    - added maximum field size for admitted patients to 'Maximum field size' section

    - added admitted patient information to the 'Data domain' section

    - removed 'ICD-10-AM' text from the admitted patient information in the 'Guide for use' section

    - removed reference to external cause codes from the 'Verification rules' section

    - modified reference to ICD-10-AM to current edition in the 'Source document' section

Alcohol and other drug treatment services NMDS

— Establishment sector

    - modified 'Guide for use' section to further explain the data domain when aligned to the more relevant definitions of 'Government' and 'Non-government'

— Main treatment type for alcohol and other drugs

    - modified 'Guide for use' section to assist clinicians coding to the data domain

— Number of service contacts within a treatment episode for alcohol and other drugs

    - removed from the NMDS

— Other treatment type for alcohol and other drugs

    - modified 'Guide for use' section to assist clinicians coding to the data domain

— Other drug of concern

    - new version number

    - addition to the 'Data domain' section of two supplementary Australian Standard Classification of Drugs of Concern (ASCDC) codes

    - addition to the 'Guide for use' section to explain the use of the two supplementary Australian Standard Classification of Drugs of Concern (ASCDC) codes

— Principal drug of concern

    - new version number

    - addition to the 'Data domain' section of two supplementary Australian Standard Classification of Drugs of Concern (ASCDC) codes
    - addition to the 'Guide for use' section to explain the use of the two supplementary Australian Standard Classification of Drugs of Concern (ASCDC) codes

— Reason for cessation of treatment episode for alcohol and other drugs
    - modified 'Guide for use' section to clarify the correct use of the data domain

— Service contact
    - removed from the NMDS

— Source of referral to alcohol and other drug treatment service
    - new version number
    - modified 'Guide for use' section to clarify the correct use of the data domain
    - modified 'Data domain' section to aid clarity

— Treatment delivery setting for alcohol and other drugs
    - new version number
    - modified the 'Definition' section to clarify the purpose of this data element

— Treatment episode for alcohol and other drugs
    - new version number
    - modified the 'Definition' section to explain when a change in the treatment setting triggers the end and beginning of a new treatment episode
    - modified the 'Guide for use' section to further clarify when a change in the treatment setting triggers the end and beginning of a treatment episode

Emergency department waiting times NMDS deleted
— Establishment number
    - modified 'Comments' section to remove reference to Emergency department waiting times NMDS.

'Foetus' to 'Fetus' modification
The following data items were modified to change the spelling of 'foetus' to 'fetus' and 'foetal' to 'fetal':
— Birth plurality
— Birthweight
— Complications of labour and delivery
— Complications of pregnancy
— Outcome of last previous pregnancy
— Maternal medical conditions
— Pregnancy — current status
— Presentation at birth
— Status of the baby
— Stillbirth (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
  - new version number
  - modified 'Context' section
  - modified 'Guide for use' section
  - modified 'Source organisation' section
  - modified 'Registration authority' section
  - added text to 'Comments' section

— Country of birth
  - new version number
  - modified 'Context' section
  - modified 'Guide for use' section
  - modified 'Collection methods' section
  - modified 'Source organisation' section
  - modified 'Registration authority' section
  - modified 'Comments' section

— Date of birth
  - new version number
  - modified 'Context' section
  - modified 'Guide for use' section
  - removed text from 'Verification rules' section
  - modified 'Collection methods' section
  - modified 'Source organisation' section
  - modified 'Registration authority' section
  - modified 'Comments' section

— Family name
  - new version number
  - added text to 'Context' section
  - modified 'Data type' section
  - modified 'Collection methods' section
  - modified 'Source organisation' section
  - modified 'Source document' section
  - modified 'Registration authority' section
  - added text to 'Comments' section

— Given name(s)
  - new version number
  - added text to 'Context' section
  - modified 'Data type' section
  - modified 'Guide for use' section

- modified 'Collection methods' section
- modified 'Source organisation' section
- modified 'Source document' section
- modified 'Registration authority' section
- added text to 'Comments' section

— Indigenous status
- new version number
- modified 'Source organisation' section
- modified 'Source document' section
- modified 'Registration authority' section
- modified 'Comments' section

— Informal carer availability
- data element name change
- new version number
- modified 'Context' section
- modified 'Collection methods' section
- modified 'Source organisation' section
- removed text from 'Source document' section
- modified 'Registration authority' section

— Labour force status
- new version number
- added text to 'Context' section
- modified 'Source organisation' section
- modified 'Source document' section
- modified 'Registration authority' section
- removed text from 'Comments' section

— Main language other than English spoken at home
- new version number
- modified 'Guide for use' section
- modified 'Collection methods' section
- modified 'Source organisation' section
- modified 'Source document' section
- modified 'Registration authority' section
- added text to 'Comments' section

— Main occupation of person
- modified data element name
- new version number
- modified 'Definition' section
- modified 'Context' section
- added text to 'Guide for use' section
- added text to 'Collection methods' section
- modified 'Source organisation' section
- modified 'Registration authority' section

- modified text in 'Comments' section
— Marital status
  - new version number
  - modified 'Definition' section
  - modified 'Context' section
  - modified 'Guide for use' section
  - modified 'Collection methods' section
  - modified 'Source organisation' section
  - added 'Source document' section
  - modified 'Registration authority' section
  - modified 'Comments' section
— Mother's original family name
  - new version number
  - added 'Context' section
  - modified 'Data type' section
  - removed text from 'Guide for use' section
  - modified 'Source organisation' section
  - modified 'Registration authority' section
  - added 'Comments' section
— Name context flag
  - new version number
  - modified 'Guide for use' section
  - deleted 'Verification rules' section
  - modified 'Source organisation' section
  - modified 'Registration authority' section
  - added 'Comments' section
— Name suffix
  - new version number
  - modified 'Data domain' section
  - modified 'Guide for use' section
  - modified 'Collection methods' section
  - modified 'Source organisation' section
  - modified 'Source document' section
  - modified 'Registration authority' section
  - added 'Comments' section
— Name title
  - new version number
  - modified 'Data domain' section
  - modified 'Guide for use' section
  - modified 'Source organisation' section
  - modified 'Source document' section
  - modified 'Registration authority' section
  - added 'Comments' section

— Person identifier
  - new version number
  - modified 'Source organisation' section
  - removed 'Source document' section
  - modified 'Registration authority' section
  - added 'Comments' section

— Postal delivery point identifier
  - new version number
  - modified 'Source organisation' section
  - modified 'Registration authority' section

— Postcode — Australian
  - new version number
  - added 'Context' section
  - modified 'Data domain' section
  - modified 'Guide for use' section
  - removed 'Verification rules' section
  - modified collection methods section
  - modified 'Source organisation' section
  - modified 'Source document' section
  - modified 'Registration authority' section
  - modified 'Comments' section

— Proficiency in spoken English
  - new version number
  - modified 'Definition' section
  - modified 'Context section'
  - modified 'Data domain' section
  - modified 'Guide for use' section
  - modified 'Collection methods' section
  - modified 'Source organisation' section
  - modified 'Registration authority' section

— Sex
  - new version number
  - modified 'Definition section'
  - modified 'Context' section
  - modified 'Data domain' section
  - modified 'Guide for use' section
  - modified 'Verification rules' section
  - modified 'Collection methods' section
  - modified 'Source organisation' section
  - added 'Source document' section
  - modified 'Registration authority' section
  - modified 'Comments' section

— Suburb/town/locality name
  - new version number
  - added 'Context' section
  - modified 'Data type' section
  - modified 'Representational class' section
  - modified 'Format' section
  - modified 'Maximum size' section
  - modified 'Data domain' section
  - added 'Guide for use' section
  - removed 'Verification rules' section
  - modified 'Collection methods' field
  - modified 'Source organisation' section
  - modified 'Registration authority' section
  - added 'Comments' section

— Telephone number
  - new version number
  - added 'Context section'
  - modified 'Source organisation' section
  - modified 'Registration authority' section
  - added 'Comments' section

— Telephone number type
  - new version number
  - modified 'Context' section
  - modified 'Guide for use' section
  - modified 'Source organisation' section
  - modified 'Registration authority' section
  - added 'Comments' section

Residential mental health care NMDS
— Additional diagnosis
  - new version number
  - modified 'Definition' section to include reference to Episode of residential care
  - modified 'Data domain' section to reference current edition of ICD-10-AM
  - added reference of 'episode of residential care' to 'Collection methods' section

— Australian state/territory identifier
  - modified 'Guide for use' section to add information on how this data element should be used in the Residential mental health care NMDS

— Diagnosis
  - new version number
  - modified 'Definition' section to include reference to Episode of residential care

— Mental health legal status
  - modified 'Definition' section to include reference to Episode of residential care
  - added text to 'Guide for use' section to indicate that the Mental health legal status may change during an episode of residential care
  - modified 'Collection methods' section to assist in the correct use of the 'Involuntary patient' option

— Principal diagnosis
  - new version number
  - modified 'Definition' section to include reference to Episode of residential care
  - modified 'Guide for use' section to add a reference to the Residential mental health care NMDS
  - added text to the 'Collection methods' section on how to record a 'Resident'

Modified references to 'third 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
  - modified 'Guide for use' section
  - modified 'Source document' section

— Additional diagnosis
  - modified 'Data domain' section
  - modified 'Source document' section

— Complication of labour and delivery
  - modified 'Data domain' section
  - modified 'Source document' section

— Complications of pregnancy
  - modified 'Data domain' section
  - modified 'Source document' section

— Congenital malformations
  - modified 'Data domain' section
  - modified 'Source document' section

— Date of procedure
  - modified 'Guide for use' section

— Diagnosis onset type
  - modified 'Guide for use' section

— External cause – admitted patient
  - modified 'Data domain' section
  - modified 'Source document' section

— Indicator procedure
  - modified 'Source document' section

— Maternal medical conditions

- modified 'Data domain' section

- modified 'Source document' section

— Neonatal morbidity

- modified 'Data domain' section

- modified 'Source document' section

— Place of occurrence of external cause of injury

- modified 'Guide for use' section

— Postpartum complication

- modified 'Data domain' section

- modified 'Source document' section

— Primary site of cancer

- modified 'Data domain' section

- modified 'Source document' section

— Principal diagnosis

- modified 'Data domain' section

- modified 'Verification rules' section

- modified 'Source document' section

— Primary site of cancer

- modified 'Data domain' section

- modified 'Source document' section

— Procedure

- modified 'Data domain' section

- modified 'Source document' section

— Vascular history

- modified 'Source document' section

— Waiting list category

- modified 'Guide for use' section

- modified 'Source document' section

New National Minimum Data Sets

Residential mental health care NMDS

The National Mental Health Working Group (NMHWG), the Information Strategy Committee (ISC) and its NMDS Subcommittee have identified residential mental health care as an area where national data are required but are practically non-existent. In response to this identified need, the ISC and its NMDS Subcommittee have recently developed a NMDS for residential mental health care.

The past ten years have seen substantial investment in reforming the mix of mental health services. A key component of these reforms has been the development of residential mental health care services as a community-orientated alternative to long-term hospital stays. While mental health service delivery has moved toward a greater emphasis on residential mental health care, the mental health information infrastructure remains predominantly hospital-based. There has been some progress in the collection of establishment-level data from these services. However there has been very little progress made in the collection of activity data. For this reason, the ISC made the development of an NMDS for residential mental health care a priority and the ISC's NMDS Subcommittee has spent over a year developing the NMDS for residential mental health care.

Once the collection has matured, the residential mental health care data will be an excellent resource for:

- understanding the nature of residential mental health care including characteristics of those using residential mental health services, the level of activity in these services and the relationship between residential mental health care services and other forms of mental health care. This information can then support policy formulation and funding decisions.

- supporting the development of casemix classifications—the data set will provide essential supplementary data for National Outcomes and Casemix Collection (NOCC) for public specialised mental health care services.

Jurisdictions will benefit through the development of nationally consistent information systems, which will allow benchmarking and comparison.

It is intended that these data will be:

- included in AIHW *Mental Health Services in Australia* publications and on-line data tables, in consultation with state and territory health authorities;

- available through the AIHW data request service, in consultation with state and territory health authorities; and

- made available to agencies participating in the Australian Mental Health Outcomes and Classification Network (AMHOCN) to assist in the development of outcome and casemix classifications.

Residential mental health care NMDS

Admin. status:	CURRENT 14/11/2003 Version number: 1
Metadata type:	NATIONAL MINIMUM DATA SET
Start date:	1 July 2004
End date:	
Latest evaluation date:	
Scope:	Episodes of residential care for residents in all government-funded residential mental health services in Australia, except those residential care services that are in receipt of funding under the *Aged Care Act* and subject to Commonwealth reporting requirements (i.e. report to the System for the Payment of Aged Residential Care (SPARC) collection).
Statistical units:	Episodes of residential care.
Collection methodology:	Data are collected at each service from resident administrative and care-related record systems. Services forward data to the relevant state or territory health authority on a regular basis (e.g. monthly).
National reporting arrangements:	State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.

South Australia maybe unable to collect this data set for 2004–05. Western Australia will be able to only collect data for 2004–05 for those data elements that were included in the *National Health Data Dictionary* version 12.

Government-operated services that employ mental health trained staff on-site 24 hours per day are to be included from 1 July 2004.

Government-funded, non-government operated services and non 24-hour staffed services can be included from 1 July 2004, optionally.

For non 24-hour staffed services to be included they must employ mental health-trained staff on-site at least 50 hours per week with at least 6 hours staffing on any single day.

Periods for which data are collected and nationally collated:	Financial years ending 30 June each year. The reference period starts on 1 July and ends on 30 June each year.
Data elements included:	Additional diagnosis, version 5♦ ....page 252

Area of usual residence, version 3♦ .... NHDD V12 page 55

Country of birth, version 4♦ ....page 266

Date of birth, version 5♦ ....page 269

Episode of residential care end date, version 1♦ ....page 146

Episode of residential care end mode, version 1♦ ....page 147

Episode of residential care start date, version 1♦ ....page 151

Episode of residential care start mode, version 1♦ ....page 153

Establishment identifier, version 4♦ .... NHDD V12 page 211

♦ new in NMDS this version   ∇ modified in NMDS this version

Supporting data elements and data element concepts:	

Data elements in common with other NMDSs:	See Appendix C.
Scope links with other NMDSs:	
Source organisation:	
Comments:	Statistical units are entities from or about which statistics are collected, or in respect of which statistics are compiled, tabulated or published. Some admitted patient care services may meet the definition of a residential mental health service. However, as they are admitted patient care services, relevant data on their patients are reported to the National Minimum Data Set for admitted patient care.

♦ new in NMDS this version   ∇ modified in NMDS this version

Existing National Minimum Data Sets

A National Minimum Data Set (NMDS) is a set of data elements agreed by the National Health Information Group for mandatory collection and reporting at a national level. One National Minimum Data Set may include data items that are also included in another National Minimum Data Set. A National Minimum Data Set is contingent upon a national agreement to collect uniform data and to supply it as part of the national collection, but does not preclude agencies and service providers from collecting additional data to meet their own specific needs.

The *National Health Data Dictionary* contains definitions of data elements that are included in National Minimum Data Set collections in the health sector, including data elements used to derive some of the performance indicators required under Australian Health Care Agreements (bilateral agreements between the Commonwealth and state/territory governments about funding and delivery of health services). The Dictionary also contains some data elements that are not currently included in any agreed National Minimum Data Set collection but have been developed and endorsed as appropriate national standards. That is, all data elements used in National Minimum Data Sets are included in the Dictionary, but not all data elements in the Dictionary are included in National Minimum Data Sets.

The following is a list of all current existing National Minimum Data Sets:

1	**Admitted patient care NMDS**
2	**Admitted patient mental health care NMDS**
3	**Admitted patient palliative care NMDS**
4	**Alcohol and other drug treatment services NMDS**
5	**Community mental health care NMDS**
6	**Community mental health establishments NMDS**
7	**Elective surgery waiting times NMDS**
8	**Health labour force NMDS**
9	**Injury surveillance NMDS**
10	**Non-admitted patient emergency department care NMDS**
11	**Perinatal NMDS**
12	**Public hospital establishments NMDS**

Admitted patient care NMDS

Admin. status:	CURRENT 1/07/2001 Version number: 2
Metadata type:	NATIONAL MINIMUM DATA SET
Start date:	1 July 1989
Scope:	Episodes of care for admitted patients in all public and private acute and psychiatric hospitals, free standing day hospital facilities and alcohol and drug treatment centres in Australia. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off shore territories may also be included. Hospitals specialising in dental, ophthalmic aids and other specialised acute medical or surgical care are included.
	Hospital boarders and still births are not included as they are not admitted to hospital. Organ procurement episodes are also not included.
Statistical units:	Episodes of care for admitted patients.
Collection methodology:	Data are collected at each hospital from patient administrative and clinical record systems. Hospitals forward data to the relevant state or territory health authority on a regular basis (e.g. monthly).
National reporting arrangements:	State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.
Periods for which data are collected and nationally collated:	Financial years ending 30 June each year.

Data elements included:

♦ new in NMDS this version   ∇ modified this version

Data elements in common with other NMDSs:

See Appendix C.

♦ new in NMDS this version   ∇ modified this version

Scope links with other NMDSs:	Episodes of care for admitted patients which occur partly or fully in designated psychiatric units of public acute hospitals or in public psychiatric hospitals:

     – Admitted patient mental health care NMDS, version 2.

       Episodes of care for admitted patients where care type is palliative care:

     – Admitted patient palliative care NMDS, version 2.

Source organisation:	National Health Information Group.
Comments:	Statistical units are entities from or about which statistics are collected, or in respect of which statistics are compiled, tabulated or published.

Admitted patient mental health care NMDS

Admin. status: CURRENT 1/07/2001 Version number: 2

Metadata type: NATIONAL MINIMUM DATA SET

Start date: 1 July 1997

Scope: The scope of this minimum data set is restricted to admitted patients receiving care in psychiatric hospitals or in designated psychiatric units in acute hospitals. The scope does not currently include patients who may be receiving treatment for psychiatric conditions in acute hospitals who are not in psychiatric units.

Statistical units: Episodes of care for admitted patients.

Collection methodology: Data are collected at each hospital from patient administrative and clinical record systems. Hospitals forward data to the relevant state or territory health authority on a regular basis (for example, monthly).

National reporting arrangements: State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.

Periods for which data are collected and nationally collated: Financial years ending 30 June each year

Data elements included:

Additional diagnosis, version 5$^\nabla$...page 252

Admission date, version 4.. NHDD V12 page 33

Area of usual residence, version 3 .... NHDD V12 page 55

Care type, version 4 .... NHDD V12 page 94

Country of birth, version 4$^\nabla$...page 266

Date of birth, version 5$^\nabla$ ....page 269

Diagnosis related group, version 1 .... NHDD V12 page 190

Employment status—acute hospital and private psychiatric hospital admissions, version 2 .... NHDD V12 page 205

Employment status—public psychiatric hospital admissions, version 2 .... NHDD V12 page 207

Establishment identifier, version 4 .... NHDD V12 page 211

Indigenous status, version 5$^\nabla$ ....page 296

Major diagnostic category, version 1..................................... NHDD V12 page 336

Marital status, version 4$^\nabla$ ....page 318

Mental health legal status, version 5$^\nabla$ ....page 322

Mode of separation, version 3 .... NHDD V12 page 358

Person identifier, version 2$^\nabla$ ....page 337

Previous specialised treatment, version 3............................. NHDD V12 page 477

Principal diagnosis, version 4$^\nabla$ ....page 353

♦ new in NMDS this version ∇ modified this version

Data elements included (continued):	Referral to further care (psychiatric patients), version 1..... NHDD V12 page 505
	Separation date, version 5... NHDD V12 page 523
	Sex, version 4$^\nabla$ ....page 365
	Source of referral to public psychiatric hospital, version 3 .... NHDD V12 page 537
	Total leave days, version 3... NHDD V12 page 586
	Total psychiatric care days, version 2.................................... NHDD V12 page 588
	Type of accommodation, version 2.. NHDD V12 page 602
	Type of usual accommodation, version 1 .... NHDD V12 page 615
Supporting data elements and data element concepts:	Acute care episode for admitted patients, version 1 .... NHDD V12 page 25
	Admission, version 3 .... NHDD V12 page 32
	Admitted patient, version 3 .... NHDD V12 page 36
	Australian state/territory identifier, version 4$^\nabla$...page 256
	Diagnosis, version 2$^\nabla$ ....page 273
	Episode of admitted patient care, version 2$^\nabla$ ....page 277
	Establishment number, version 4$^\nabla$ ....page 278
	Establishment sector, version 4$^\nabla$ ....page 279
	Hospital, version 1 .... NHDD V12 page 279
	Patient, version 1.. NHDD V12 page 437
	Region code, version 2.. NHDD V12 page 508
	Separation, version 3 .... NHDD V12 page 522
Data elements in common with other NMDSs:	See Appendix C.
Scope links with other NMDSs:	Episodes of care for admitted patients which occur partly or fully in designated psychiatric units of public acute hospitals or in public psychiatric hospitals:
	– Admitted patient care NMDS, version 2
	– Admitted patient palliative care NMDS, version 2.
Source organisation:	National Health Information Group.
Comments:	Statistical units are entities from or about which statistics are collected or in respect of which statistics are compiled, tabulated or published.
	Number of days of hospital in the home care data will be collected from all states and territories except Western Australia from 1 July 2001. Western Australia will begin to collect data from a later date.

♦ new in NMDS this version ∇ modified this version

Admitted patient palliative care NMDS

Admin. status:	CURRENT 1/07/2001 Version number: 2
Metadata type:	NATIONAL MINIMUM DATA SET
Start date:	1 July 2000

Scope: The scope of this data set is admitted patients receiving palliative care in all public and private acute hospitals, and free standing day hospital facilities. Hospitals operated by the Australian Defence Force, correctional authorities and Australia's external territories are not currently included.

Palliative care patients are identified by the data element Care type.

Statistical units: Episodes of care for admitted patients.

Collection methodology:

National reporting arrangements: State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.

Periods for which data are collected and nationally collated: Financial years ending 30 June each year

Data elements included:

Additional diagnosis, version 5$^\nabla$ ....page 252

Admission date, version 4.. NHDD V12 page 33

Area of usual residence, version 3 .... NHDD V12 page 55

Care type, version 4 .... NHDD V12 page 94

Country of birth, version 4$^\nabla$ ....page 266

Date of birth, version 5$^\nabla$ ....page 269

Establishment identifier, version 4 .... NHDD V12 page 211

Funding source for hospital patient, version 1 .... NHDD V12 page 245

Indigenous status, version 5$^\nabla$ ....page 296

Mode of admission, version 4.. NHDD V12 page 357

Mode of separation, version 3 .... NHDD V12 page 358

Number of days of hospital-in-the-home care, version 1 ... NHDD V12 page 405

Person identifier, version 2$^\nabla$ ....page 337

Previous specialised treatment, version 3............................. NHDD V12 page 477

Principal diagnosis, version 4$^\nabla$ ....page 353

Separation date, version 5... NHDD V12 page 523

Sex, version 4$^\nabla$ ....page 365

Supporting data elements and data element concepts:

Admission, version 3 .... NHDD V12 page 32

Admitted patient, version 3... NHDD V12 page 36

♦ new in NMDS this version   ∇ modified this version

Data elements in common with other NMDSs: See Appendix C.

Scope links with other NMDSs: Episodes of care for admitted patients which occur partly or fully in designated psychiatric units of public acute hospitals or in public psychiatric hospitals:

– Admitted patient care NMDS, version 2

– Admitted patient mental health care NMDS, version 2.

Source organisation: National Health Information Group.

Comments: Statistical units are entities from or about which statistics are collected or in respect of which statistics are compiled, tabulated or published.

Number of days of hospital in the home care data will be collected from all states and territories except Western Australia from 1 July 2001. Western Australia will begin to collect data from a later date.

♦ new in NMDS this version   ∇ modified this version

Alcohol and other drug treatment services NMDS

Admin. status:	CURRENT 1/07/2003 Version number: 4
Metadata type:	NATIONAL MINIMUM DATA SET
Start date:	1 July 2000
Scope:	This metadata set is nationally mandated for collection and reporting.

Publicly funded government and non-government agencies providing alcohol and/or drug treatment services. Including community-based ambulatory services and outpatient services.

The following services are currently not included in the coverage:

– services based in prisons and other correctional institutions

– agencies that provide primarily accommodation or overnight stays such as 'sobering-up shelters' and 'halfway houses'

– agencies that provide services concerned primarily with health promotion

– needle and syringe programs

– agencies whose sole function is to provide prescribing and/or dosing of methadone

– acute care and psychiatric hospitals, or alcohol and drug treatment units that report to the admitted patient care NMDS and do not provide treatment to non-admitted patients.

Clients who are on a methadone maintenance program may be included in the collection where they also receive other types of treatment.

Statistical units: Completed treatment episodes for clients who participate in a treatment type as specified in the data element Main treatment type for alcohol and other drugs.

Collection methodology: Data to be reported in each agency on completed treatment episode and then forwarded to state/territory authorities for collation.

National reporting arrangements: State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation on an annual basis.

Periods for which data are collected and nationally collected: Financial years ending 30 June each year.

Data elements included: Client type — alcohol and other drug treatment services, version 3 ....NHDD V12 page 118

Country of birth, version 4$^\nabla$.. page 266

Date of birth, version 5$^\nabla$ .... page 269

Date of cessation of treatment episode for alcohol and other drugs, version 2..NHDD V12 page 153

Date of commencement of treatment episode for alcohol and other drugs, version 2 ....NHDD V12 page 157

Establishment identifier, version 4 ....NHDD V12 page 211

♦ new in NMDS this version   ∇ modified this version

Data elements in common   See Appendix C.
with other Metadata sets:

Source organisation: National Health Information Group.

Comments: Statistical units are entities from or about which statistics are collected, or in
                                respect of which statistics are compiled, tabulated or published.

♦ new in NMDS this version ∇ modified in NMDS this version

Community mental health care NMDS

Admin. status:	CURRENT 1/07/2001 Version number: 2
Metadata type:	NATIONAL MINIMUM DATA SET
Start date:	1 July 2000
End date:	
Latest evaluation date:	

Scope: Patient level data:

Data required for reporting by specialised psychiatric services that deliver ambulatory services, in both institutional and community settings. It does not extend to services provided to patients who are in general (non-specialised) care who may be receiving treatment or rehabilitation for psychiatric conditions.

The data provided through the Community mental health care NMDS supplements that reported for psychiatric and acute care hospitals through the Admitted patient mental health care NMDS.

Statistical units: Service contact.

Collection methodology:

National reporting arrangements: State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.

Periods for which data are collected and nationally collated: Financial years ending 30 June each year.

Data elements included:

Area of usual residence, version 3 .... NHDD V12 page 55

Country of birth, version 4$^\nabla$..page 266

Date of birth, version 5$^\nabla$ ....page 269

Establishment identifier, version 4 .... NHDD V12 page 211

Indigenous status, version 5$^\nabla$ ....page 296

Marital status, version 4$^\nabla$ ....page 318

Mental health legal status, version 5$^\nabla$ ....page 322

Person identifier, version 2$^\nabla$ ....page 337

Principal diagnosis, version 4$^\nabla$..page 353

Service contact date, version 1.. NHDD V12 page 529

Sex version 4$^\nabla$ ....page 365

Supporting data elements and data element concepts:

Australian state/territory identifier, version 4$^\nabla$..page 256

Diagnosis, version 2$^\nabla$ ....page 273

Establishment number, version 4$^\nabla$...page 278

Establishment sector, version 4$^\nabla$ ....page 279

♦ new in NMDS this version ∇ modified this version

Supporting data elements and data element concepts (continued):	Region code, version 2.. NHDD V12 page 508	
	Service contact, version 1 .... NHDD V12 page 527	
Data elements in common with other NMDSs:	See Appendix C.	
Scope links with other NMDSs:		
Source organisation:	National Health Information Group.	
Comments:	Statistical units are entities from or about which statistics are collected or in respect of which statistics are compiled, tabulated or published.	

Community mental health establishments NMDS

Admin. status:	CURRENT 1/07/2000 Version number: 1
Metadata type:	NATIONAL MINIMUM DATA SET
Start date:	1 July 1998
End date:	
Latest evaluation date:	
Scope:	Data required for reporting by specialised psychiatric services that deliver ambulatory services, in both institutional and community settings, and/or community-based residential care. It does not extend to services provided to patients who are in general (non-specialised) care who may be receiving treatment or rehabilitation for psychiatric conditions.
	The data provided through the NMDS – Community mental health establishments supplements that reported for psychiatric and acute care hospitals through the NMDS – Admitted patient mental health care.
Statistical units:	Establishment-level data.
Collection methodology:	
National reporting arrangements:	State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation on an annual basis.
Periods for which data are collected and nationally collated:	Financial years ending 30 June each year.

Data elements included:

Establishment identifier, version 4 .... NHDD V12 page 211

Full time equivalent staff, version 2 .... NHDD V12 page 243

Geographical location of establishment, version 2 .... NHDD V12 page 247

Non-salary operating costs, version 1 .... NHDD V12 page 399

Number of available beds for admitted patients, version 2
.... NHDD V12 page 401

Salaries and wages, version 1 .... NHDD V12 page 517

Separations, version 2 .... NHDD V12 page 526

Specialised mental health service setting, version 1♦ .... page 217

Supporting data elements and data element concepts:

Administrative expenses, version 1 .... NHDD V12 page 31

Australian state/territory identifier, version 4∇ .... page 256

Depreciation, version 1 .... NHDD V12 page 181

Domestic services, version 1 .... NHDD V12 page 193

Drug supplies, version 1 .... NHDD V12 page 194

Establishment number, version 4∇ .... page 278

Establishment sector, version 4∇ .... page 279

Food supplies, version 1 .... NHDD V12 page 233

Interest payments, version 1 .... NHDD V12 page 317

♦ new in NMDS this version   ∇ modified in NMDS this version

Supporting data elements and data element concepts (continued):	Medical and surgical supplies, version 1	NHDD V12 page 341
	Other recurrent expenditure, version 1	NHDD V12 page 429
	Patient, version 1	NHDD V12 page 437
	Patient transport, version1	NHDD *V12* page 444
	Payments to visiting medical officers, version 1	NHDD V12 page 446
	Region code, version 2	NHDD V12 page 508
	Repairs and maintenance, version 1	NHDD V12 page 514
	Separation, version 3	NHDD V12 page 522
	Specialised mental health service, version 1$^\nabla$	page 215
	Superannuation employer contributions (including funding basis), version 1	NHDD V12 page 548

Data elements in common with other NMDSs:	See Appendix C.
Scope links with other NMDSs:	
Source organisation:	National Health Information Group.

♦ new in NMDS this version ∇ modified in NMDS this version

Elective surgery waiting times NMDS

Admin. status:	CURRENT 1/07/2001 Version number: 3
Metadata type:	NATIONAL MINIMUM DATA SET
Start date:	1 July 1994
End date:	
Latest evaluation date:	

Scope:

The scope of this minimum data set is patients on, or removed from, waiting lists for elective surgery (as defined in the Waiting list category data element) which are managed by public acute hospitals. This will include private patients treated in public hospitals, and may include public patients treated in private hospitals.

Hospitals may also collect information for other care (as defined in the Waiting list category data element), but this is not part of the NMDS for elective surgery waiting times.

Patients on, or removed from, waiting lists managed by hospitals operated by the Australian Defence Force, corrections authorities and Australia's external territories are not currently included.

There are two different types of data collected for this minimum data set (census data and removals data) and the scope and list of data elements associated with each is different.

Census data:

Data are collected for patients on elective surgery waiting lists who are yet to be admitted to hospital or removed for another reason. The scope is patients on elective surgery waiting lists on a census date who are 'ready for care' as defined in the Patient listing status data element.

Removals data:

Data are collected for patients who have been removed from an elective surgery waiting list (for admission or another reason). Patients who were 'ready for care' and patients who were 'not ready for care' at the time of removal are included.

Statistical units:

Patients on waiting lists on census dates; patients removed from waiting lists (for admission or other reason) during each financial year.

Collection methodology:

Category reassignment date is required for reporting to the NMDS, but is necessary for the derivation of Waiting time at census date and Waiting time at removal from elective surgery waiting list. Waiting list category and Patient listing status are not required for reporting to the NMDS, but are necessary for determining whether patients are in scope for the NMDS. These data elements should be collected at the local level and reported to state and territory health authorities as required.

National reporting arrangements:

State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation on an annual basis.

Periods for which data are collected and nationally collated:

Financial years ending 30 June each year for removals data.
Census dates are 30 September, 31 December, 31 March and 30 June.

Data elements included: **Census data**

Census date, version 2.. NHDD V12 page 103

Clinical urgency, version 2 .... NHDD V12 page 123

Establishment identifier, version 4 .... NHDD V12 page 211

Extended wait patient, version 1 .... NHDD V12 page 221

Indicator procedure, version 3 .... NHDD V12 page 297

Listing date for care, version 4 .... NHDD V12 page 327

Overdue patient, version 3 .... NHDD V12 page 434

Surgical specialty, version 1 .... NHDD V12 page 550

Waiting time at a census date, version 2........................... NHDD V12 page 638

Removals data

Clinical urgency, version 2 .... NHDD V12 page 123

Extended wait patient, version 1 .... NHDD V12 page 221

Establishment identifier, version 4 .... NHDD V12 page 211

Indicator procedure, version 3 .... NHDD V12 page 297

Listing date for care, version 4 .... NHDD V12 page 327

Overdue patient, version 3 .... NHDD V12 page 434

Reason for removal from elective surgery waiting list,
version 4 .... NHDD V12 page 501

Removal date, version 1 .... NHDD V12 page 509

Surgical specialty, version 1 .... NHDD V12 page 550

Waiting time at removal from elective surgery
waiting list, version 2 .... NHDD V12 page 640

Supporting data elements   Australian state/territory identifier, version 4$^{\nabla}$ .... page 256
and data element
concepts: Category reassignment date, version 2........................... NHDD V12 page 102

Clinical review, version 1 .... NHDD V12 page 122

Elective care, version 1 .... NHDD V12 page 197

Elective surgery, version 1... NHDD V12 page 198

Establishment number, version 4$^{\nabla}$ .... page 278

Establishment sector, version 4$^{\nabla}$ .... page 279

Hospital census, version 1 .... NHDD V12 page 281

Hospital waiting list, version 2 .... NHDD V12 page 284

Non-elective care, version 1 .... NHDD V12 page 398

Patient listing status, version 3 .... NHDD V12 page 440

Region code, version 2 .... NHDD V12 page 508

Waiting list category, version 3$^{\nabla}$.. page 386

Data elements in   See Appendix C.
common with other
NMDSs:

♦ new in NMDS this version   ∇ modified this version

Scope links with other NMDSs:

Source organisation: National Health Information Group.

Comments: For the purposes of this NMDS, public hospitals include hospitals which are set up to provide services for public patients (as public hospitals do), but which are managed privately.

Comments (continued):   Category reassignment date is not required for reporting to the NMDS, but is necessary for the derivation of Waiting time at census date and Waiting time at removal from elective surgery waiting list. Waiting list category and Patient listing status are not required for reporting to the NMDS, but are necessary for determining whether patients are in scope for the NMDS. These data elements should be collected at the local level and reported to State and territory health authorities as required.

The inclusion of public patients on, or removed from, elective surgery waiting lists managed by private hospitals will be investigated in the future.

Statistical units are entities from or about which statistics are collected or in respect of which statistics are compiled, tabulated or published.

Health labour force NMDS

Admin. status:	CURRENT 1/07/2000 Version number: 1
Metadata type:	NATIONAL MINIMUM DATA SET
Start date:	1 July 1989
End date:	
Latest evaluation date:	
Scope:	The scope of this set of data elements is all health occupations. National collections using this data set have been undertaken for the professions of medicine, nursing, dentistry pharmacy, physiotherapy and podiatry, using labour force questionnaires in the annual renewal of registration to practice.
Statistical units:	
Collection methodology:	
National reporting arrangements:	State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.
Periods for which data are collected and nationally collated:	Financial years ending 30 June each year.

Data elements included:

Classification of Health labour force job, version 1 .... NHDD V12 page 115

Date of birth, version 5$^\nabla$ .... page 269

Hours on-call (not worked) by medical practitioner,
version 2 .... NHDD V12 page 287

Hours worked by health professional, version 2 .... NHDD V12 page 289

Hours worked by medical practitioner in direct patient care,
version 2 .... NHDD V12 page 291

Principal area of clinical practice, version 1 .... NHDD V12 page 481

Principal role of health professional, version 1 .... NHDD V12 page 487

Profession labour force status of health professional,
version 1…………………………………………………………..NHDD V12 page 491

Total hours worked by medical practitioner, version 2 ...... NHDD V12 page 584

Type and sector of employment establishment, version 1 . NHDD V12 page 600

Supporting data elements and data element concepts:

Health labour force, version 1 .... NHDD V12 page 265

Data elements in common with other NMDSs:

See Appendix C.

Scope links with other NMDSs:

♦ new in NMDS this version   ∇ modified this version

Source organisation: National Health Information Group.

Comments: Statistical units are entities from or about which statistics are collected or in respect of which statistics are compiled, tabulated or published.

Injury surveillance NMDS

Admin. status:	CURRENT 1/07/2000 Version number: 1
Metadata type:	NATIONAL MINIMUM DATA SET
Start date:	1 July 1989
End date:	
Latest evaluation date:	
Scope:	The scope of this minimum data set is patient level data from selected emergency departments of hospitals and other settings.
Statistical units:	
Collection methodology:	
National reporting arrangements:	State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.
Periods for which data are collected and nationally collated:	Financial years ending 30 June each year.

Data elements included:

Activity when injured, version 3^∇ .... page 248

Bodily location of main injury, version 1 .... NHDD V12 page 77

External cause — admitted patient, version 4^∇ .... page 281

External cause — human intent, version 4 .... NHDD V12 page 224

Narrative description of injury event, version 1 .... NHDD V12 page 375

Nature of main injury—non-admitted patient, version 1... NHDD V12 page 376

Place of occurrence of external cause of injury, version 6^∇ .... page 339

Supporting data elements and data element concepts:

Admitted patient, version 3 .... NHDD V12 page 36

Non-admitted patient, version 1 .... NHDD V12 page 385

Data elements in common with other NMDSs:	See Appendix C.
Scope links with other NMDSs:	
Source organisation:	National Health Information Group.
Comments:	Statistical units are entities from or about which statistics are collected or in respect of which statistics are compiled, tabulated or published.

♦ new in NMDS this version   ∇ modified this version

Non-admitted patient emergency department care NMDS

Admin. status:	01/07/2003 Version number: 1
Metadata type:	NATIONAL MINIMUM DATA SET
Start date:	1 July 2003
Scope:	This metadata set is nationally mandated for collection and reporting.

The scope of this NMDS is non-admitted patients registered for care in emergency departments in selected public hospitals that are classified as either Peer Group A or B in the Australian Institute of Health and Welfare's *Australian Hospital Statistics* publication from the preceding financial year.

The care provided to patients in emergency departments is, in most instances, recognised as being provided to 'non-admitted' patients. Patients being treated in emergency departments may subsequently become 'admitted'. The care provided to non-admitted patients who are treated in the emergency department prior to being admitted is included in this NMDS.

Care provided to patients who are being treated in an emergency department site as an admitted patient (e.g. in an observation unit, short-stay unit, 'Emergency department ward' or awaiting a bed in an admitted patient ward of the hospital) are excluded from the emergency department care NMDS since the recording of the care provided to these patients is part of the scope of the Admitted patient care NMDS.

Statistical units:	Non-admitted patient emergency department service episodes.
National reporting arrangements:	State and territory health authorities provide the NMDS data to the Australian Institute of Health and Welfare for national collation, on an annual basis, within 3 months of the end of a reporting period.

The Institute and the Commonwealth Department of Health and Ageing will agree on a data quality and timeliness protocol. Once cleaned, a copy of the data and a record of the changes made will be forwarded by the Institute to the Commonwealth Department of Health and Ageing. A copy of the cleaned data for each jurisdiction should also be returned to that jurisdiction on request.

Periods for which data are collected and nationally collated:	Financial years, ending 30 June each year. Extraction of data for a financial year should be based on the date of the end of the non-admitted emergency department service episode.
Data elements included:	Area of usual residence, version 3 .... NHDD V12 page 55

Compensable status, version 3 .... NHDD V12 page 126

Country of birth, version 4$^\nabla$ .... page 266

Date of birth, version 5$^\nabla$ .... page 269

Date patient presents, version 2 .... NHDD V12 page 171

Department of Veterans' Affairs patient, version 1 .... NHDD V12 page 176

Emergency department arrival mode — transport,
version 1 .... NHDD V12 page 200

        ♦ new in NMDS this version   ∇ modified this version

Data elements included (continued):	Emergency department departure status, version 2 .... NHDD V12 page 201
	Emergency department waiting time to service delivery, version 2 .... NHDD V12 page 204
	Establishment identifier, version 4 .... NHDD V12 page 211
	Indigenous status, version 5$^\nabla$ .... page 296
	Length of non-admitted patient emergency department service episode, version 1 .... NHDD V12 page 322
	Person identifier, version 2$^\nabla$ .... page 337
	Sex, version 4$^\nabla$ .... page 365
	Time patient presents, version 2 .... NHDD V12 page 560
	Triage category, version 1 .... NHDD V12 page 594
	Type of visit to emergency department, version 2 .... NHDD V12 page 616
Supporting data elements and data element concepts:	Australian state/territory identifier, version 4$^\nabla$ .... page 256
	Emergency department — public hospital, version 1 ..... NHDD V12 page 199
	Establishment number, version 4$^\nabla$ .... page 278
	Establishment sector, version 4$^\nabla$ .... page 279
	Non-admitted patient emergency department service episode, version 1 .... NHDD V12 page 386
	Patient presentation at emergency department, version 1 .... NHDD V12 page 442
	Region code, version 2 .... NHDD V12 page 508
Data elements in common with other Metadata sets:	See Appendix C.
Scope links with other Metadata sets:	Episodes of care for admitted patients are reported through the Admitted patient care NMDS.
Source organisation:	National Health Information Group.
Comments:	

♦ new in NMDS this version   ∇ modified this version

Perinatal NMDS

Admin. status:	CURRENT 1/07/2001 Version number: 1
Metadata type:	NATIONAL MINIMUM DATA SET
Start date:	1 July 1997
End date:	
Latest evaluation date:	

Scope: The scope of this minimum data set is all births in Australia in hospitals, birth centres and the community. The data set includes information on all births, both live and stillborn, of at least 20 weeks gestation or 400g birth weight.

Statistical units:

Collection methodology:

National reporting arrangements: State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.

Periods for which data are collected and nationally collated: Financial years ending 30 June each year.

Data elements included:

Actual place of birth, version 2^∇ ....page 250

Birth order, version 1 .... NHDD V12 page 63

Birth plurality, version 1^∇ ....page 258

Country of birth, version 4^∇ ....page 266

Date of birth, version 5^∇ ....page 269

Establishment identifier, version 4.............................. NHDD V12 page 211

First day of last menstrual period, version 1 .... NHDD V12 page 232

Gestational age, version 1.. NHDD V12 page 252

Indigenous status, version 5^∇ ....page 296

Infant weight, neonate, stillborn, version 3................................ NHDD V12 page 306

Method of birth, version 1 .... NHDD V12 page 348

Onset of labour, version 2.. NHDD V12 page 421

Person identifier, version 2^∇ ....page 337

Separation date, version 5 .... NHDD V12 page 523

Sex, version 4^∇ ....page 365

Status of the baby, version 1^∇ ....page 370

Supporting data elements and data element concepts:

Australian state/territory identifier, version 4^∇ ....page 256

Birthweight, version 1^∇ ....page 260

Establishment number, version 4^∇ ....page 278

♦ new in NMDS this version ∇ modified this version

Supporting data elements and data element concepts (continued):	Establishment sector, version 4[∇]...page 279

Data elements in common with other NMDSs:	See Appendix C.
Scope links with other NMDSs:	
Source organisation:	National Health Information Group.
Comments:	Statistical units are entities from or about which statistics are collected or in respect of which statistics are compiled, tabulated or published.

♦ new in NMDS this version   ∇ modified this version

Public hospital establishments NMDS

Admin. status: CURRENT   1/07/2000   Version number: 1

Metadata type: NATIONAL MINIMUM DATA SET

Start date: 1 July 1989

End date:

Latest evaluation date:

Scope: The scope of this dataset is establishment level data for public acute and psychiatric hospitals, including hospitals operated for or by the Australian Government Department of Veterans' Affairs, and alcohol and drug treatment centres.

From version 9 Patient–level data remains in the new NMDS called Admitted patient care. These new NMDS replace the version 8 NMDS called Institutional health care.

Similar data for private hospitals and free standing day hospital facilities is collected by the Australian Bureau of Statistics in the Private Health Establishments Collection.

Hospitals operated by the Australian Defence Force, corrections authorities and Australia's external territories are not currently included. Hospitals specialising in dental, ophthalmic aids and other specialised acute medical or surgical care are included.

Statistical units: Public hospital establishments.

Collection methodology: Data are collected at each hospital from patient administrative and clinical record systems. Hospitals forward data to the relevant state or territory health authority on a regular basis (for example, monthly).

National reporting arrangements: State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.

Periods for which data are collected and nationally collated: Financial years ending 30 June each year.

Data elements included:
Administrative expenses, version 1 .... NHDD V12 page 31

Capital expenditure, version 1 .... NHDD V12 page 86

Capital expenditure — gross (accrual accounting), version 2.... NHDD V12 page 88

Capital expenditure — net (accrual accounting), version 2 .... NHDD V12 page 90

Depreciation, version 1 .... NHDD V12 page 181

Domestic services, version 1 .... NHDD V12 page 193

Drug supplies, version 1 .... NHDD V12 page 194

Establishment identifier, version .... NHDD V12 page 211

Establishment type, version 1 .... NHDD V12 page 215

Food supplies, version 1 .... NHDD V12 page 233

Full-time equivalent staff, version 2 .... NHDD V12 page 243

Geographical location of establishment, version 2 .... NHDD V12 page 247

♦ new in NMDS this version   ∇ modified this version

Data elements included (continued):	Group sessions, version 1 .... NHDD V12 page 264	
	Indirect health care expenditure, version 1 .... NHDD V12 page 303	
	Individual/group session, version 1 .... NHDD V12 page 305	
	Interest payments, version 1 .... NHDD V12 page 317	
	Medical and surgical supplies, version 1 .... NHDD V12 page 341	
	Number of available beds for admitted patients, version 2 ..... NHDD V12 page 401	
	Occasions of service, version 1 .... NHDD V12 page 418	
	Other recurrent expenditure, version 1 .... NHDD V12 page 429	
	Other revenues, version 1 .... NHDD V12 page 430	
	Patient revenue, version 1 .... NHDD V12 page 443	
	Patient transport, version 1 .... NHDD V12 page 444	
	Payments to visiting medical officers, version 1 .... NHDD V12 page 446	
	Recoveries, version 1 .... NHDD V12 page 503	
	Repairs and maintenance, version 1 .... NHDD V12 page 514	
	Salaries and wages, version 1 .... NHDD V12 page 517	
	Specialised service indicators, version 1 .... NHDD V12 page 538	
	Superannuation employer contributions (including funding basis), version 1 .... NHDD V12 page 548	
	Teaching status, version 1 .... NHDD V12 page 552	
	Type of non-admitted patient care, version 1 .... NHDD V12 page 607	
	Type of non-admitted patient care (public psychiatric, alcohol and drug), version 1 .... NHDD V12 page 611	

Supporting data elements and data element concepts:	Australian state/territory identifier, version 4$^\nabla$ ....page 256
	Establishment number, version 4$^\nabla$ ....page 278
	Establishment sector, version 4$^\nabla$ ....page 279
	Hospital, version 1 .... NHDD V12 page 279
	Hospital boarder, version 1 .... NHDD V12 page 280
	Non-admitted patient, version 1 .... NHDD V12 page 385
	Overnight-stay patient, version 3 .... NHDD V12 page 436
	Patient, version 1 .... NHDD V12 page 437
	Region code, version 2 .... NHDD V12 page 508
	Same-day patient, version 1 .... NHDD V12 page 519
	Separation, version 3 .... NHDD V12 page 522

Data elements in common with other NMDSs:	See Appendix C.
Scope links with other NMDSs:	Episodes of care for admitted patients which occur partly or fully in designated psychiatric units of public acute hospitals or in public psychiatric hospitals:

- – Admitted patient care NMDS, version 1

- – Admitted patient mental health care NMDS, version 1

- – Admitted patient palliative care NMDS, version 1

♦ new in NMDS this version   ∇ modified this version

Source organisation:	National Health Information Group.
Comments:	Statistical units are entities from or about which statistics are collected or in respect of which statistics are compiled, tabulated or published.

New data set specifications

Acute coronary syndrome (clinical)

Acute coronary syndrome (heart attack or unstable angina) remains a substantial contributor to morbidity and mortality despite the advances in therapeutic options in this field over recent years.

While several local and international bodies have endorsed an inclusive data set for the clinical monitoring and management of patients presenting with acute coronary syndrome (ACS), a national standard for these data elements has not been established before now. It is hoped that the development of a national standard for these definitions will facilitate a more uniform data collection and research collaboration, contribute to greater accuracy in evaluating the impact of the expanding therapeutic options in these clinical areas, as well as lead to improvements in the quality of care through standardised outcome evaluation. As an initiative of the National Heart Foundation of Australia (NHFA) and the Cardiac Society of Australia and New Zealand (CSANZ), a working group was formed to develop a set of standard data elements and definitions for patients presenting with acute coronary syndrome. This working group sought to include broad representation from many interested organisations within the field. The development of this data set specification (DSS) by the Acute Coronary Syndromes Data Set Working Group (ACSDWG) was supported by the National Heart, Stroke and Vascular Health Strategies Group (NHSVHSG) and thus given a more formal level of recognition for this initiative within the Commonwealth National Health Priorities Areas structures and work agenda.

The data set has undergone an extensive consultation process. Comments received from the Health Data Standards Committee led to the ACS Data Working Group adopting a tiered approach to finalising the data elements considered a high priority for inclusion in this *National Health Data Dictionary* Version 12 Supplement. Data elements of less priority may be developed and put forward for inclusion into the Knowledgebase and subsequent versions of the NHDD at a later date.

The data elements included in this DSS represent a non-mandatory data set encompassing the core elements considered necessary for clinical outcome assessment and basic risk adjustment. Acute Coronary Syndrome data are primarily designed for use by hospital-based clinicians involved in the care of patients presenting with ACS, enabling them to evaluate risk factors and clinical outcomes in a manner that is consistent nationally and internationally. This is to encourage objective evaluation of local practice patterns and therapeutic utilisation with data that are interpretable outside the local context. The definitions within this data set are considered important risk markers with established value in predicting clinical outcome and guiding therapy, while the outcome definitions have been shown clearly to have an impact on patients not only at the level of morbidity and mortality but also at a social level.

Acute coronary syndrome (clinical) DSS

Admin. status:	CURRENT 04/06/2004 Version number: 1
Metadata type:	DATA SET SPECIFICATION
Start date:	04/06/2004
Scope:	This Acute coronary syndrome (clinical) data set specification is not mandated for collection but is recommended as best practice. The specification is intended for use in data collections in hospitals, coronary care units and other relevant acute care practices.

Acute coronary syndromes reflect the spectrum of coronary artery disease resulting in acute myocardial ischaemia, and span unstable angina, non-ST segment elevation myocardial infarction (NSTEMI) and ST-segment elevation myocardial infarction (STEMI). Clinically these diagnoses encompass a wide variation in risk, require complex and time urgent risk stratification and represent a large social and economic burden.

The definitions used in ACS data are designed to underpin the data collected by health professionals in their day-to-day acute care practice. They relate to acute clinical consultations for patients presenting with chest pain/ discomfort and the need to correctly identify, evaluate and manage patients at increased risk of a coronary event.

The data elements specified in this metadata set provide a framework for:

 – promoting the delivery of evidenced-based acute coronary syndrome management care to patients;

 – facilitating the ongoing improvement in the quality and safety of acute coronary syndrome management in acute care settings in Australia and New Zealand;

 – improving the epidemiological and public health understanding of this syndrome; and

 – supporting acute care services as they develop information systems to complement the above.

This is particularly important as the scientific evidence supporting the development of the data elements within ACS data indicate that accurate identification of the evolving myocardial infarction patient or the high/intermediate risk patient leading to the implementation of the appropriate management pathway impacts on the patient's outcome. Having a nationally recognised set of definitions in relation to defining a patient's diagnosis, risk status and outcomes is a prerequisite to achieving the above aims.

ACS data are based on the American College of Cardiology (ACC) Data Set for Acute Coronary Syndrome as published in the Journal of the American College of Cardiology in December 2001 (38:2114–30) as well as more recent scientific evidence around the diagnosis of myocardial infarction. The data elements are alphabetically listed and grouped in a similar manner to the American College of Cardiology's data set format. These features of the Australian ACS data set should ensure that the data is internationally comparable.

The data elements described here have been identified as high priority for inclusion in the NHDD for the collection of data relating to ACS management, along with supporting elements already existing within the

NHDD (as listed). It is recommended that other data elements be collected as best practice—however, these are not listed here, as they are considered to be of a secondary priority. Such data elements include date of coronary artery bypass grafting (CABG), percutaneous coronary intervention (PCI) and diagnostic cardiac catheterisation/angiography and recording the number of units of blood transfused.

Many of the data elements in this metadata set may also be used in the collection of other cardiovascular clinical information.

Where appropriate, it may be useful if the data definitions in this metadata set were used to address data definition needs in non-clinical environments such as public health surveys etc. This could allow for qualitative comparisons between data collected in, and aggregated from, clinical settings (i.e. using application of ACS data), with that collected through other means (e.g. public health surveys, reports).

A set of core ACS data elements and standardised definitions can inform the development and conduct of future registries at both the national and local level.

The working group formed under the National Heart Foundation of Australia (NHFA) and the Cardiac Society of Australia and New Zealand (CSANZ) initiative was diverse and included representation from the following organizations: the NHFA, the CSANZ, the Australasian College of Emergency Medicine, the Australian Institute of Health and Welfare, the Australasian Society of Cardiac and Thoracic Surgeons, Royal Australian College of Physicians (RACP), RACP—Towards a Safer Culture, National Centre for Classification in Health (Brisbane), the NSW Aboriginal Health and Medical Research Council, the George Institute for International Health, the School of Population Health at the University of Western Australia and the National Cardiovascular Monitoring System Advisory Committee.

To ensure the broad acceptance of the data set, the working group also sought consultation from the heads of cardiology departments, other specialist professional bodies and regional key opinion leaders in the field of acute coronary syndromes.

Collection methodology:　　This metadata set is primarily concerned with the clinical use of ACS data. Acute care environments such as hospital emergency departments, coronary care units or similar acute care areas are the settings in which implementation of the core ACS data set should be considered. A wider range of health and health-related establishments that create, use or maintain, records on health care clients, could also use it.

Data elements included:　　**Baseline characteristics**

Clinical evidence status, version 1◆..page 112

Concurrent clinical condition — on presentation, version 1◆.........page 118

Country of birth, version 4◆..page 266

Date of birth, version 5◆...page 269

Diabetes status, version 1◆ .... NHDD V12 page 182

Height — self-reported, version 2◆ .... NHDD V12 page 274

Indigenous status, version 5◆ ....page 296

◆ new in NMDS this version　　　　　　　　　∇ modified this version

Data elements included (continued):

Clinical presentation

ECG findings

Laboratory tests

♦ new in NMDS this version   ∇ modified this version

Supporting data elements and data element concepts:

Scope links with other metadata sets:

Source organisation:

Comments:

◆ new in NMDS this version   ∇ modified this version

Cancer (clinical)

Prior to this data set specification (DSS), there was no standardised approach to the collection of variables that would enable national patterns of cancer survival by stage at diagnosis or cancer patient management to be assessed. Population-based state cancer registries collect data from which incidence, mortality and overall survival rates can be estimated and trends monitored. The extent to which the care and treatment of cancer patients across different treatment facilities is consistent with available best practice recommendations cannot be easily monitored even though such information can aid our understanding of variations in practice and equity of access to treatment modalities. Treatment and outcomes data are also important for quality assurance and improving the quality of care.

In its December 1997 report *National Cancer Control Plan and Implementation Strategy* the National Cancer Control Initiative (NCCI) identified gaps in current cancer control data and made several recommendations to meet 'urgent national needs' for improved data collection. An ad-hoc Advisory Group was convened to develop outlines designed to seek consensus on data needs across the continuum of cancer care in Australia.

In April 1999, Professor Alan Coates was commissioned to undertake a wide ranging consultation to identify data currently collected on cancer care in Australia and overseas, to recommend core items for a clinical cancer data set and to suggest suitable definitions for these items. In compiling his report, Professor Coates sought input from the state-based cancer registries, oncology units and hospital-based cancer registries and state Health Departments in all Australian states and from a number of international cancer registries. The data items proposed reflected 'a reasonable compromise between a set too large to be attainable and one too small to be interesting' and included items relating to the stage of cancer at diagnosis, initial treatment details and treatment outcomes. The report, submitted to the NCCI in January 2000, was circulated to key stakeholders for comment and, at a workshop held in July 2000 to discuss the report, a core set of data items was recommended and a working party established to develop definitions for these items.

A multi-disciplinary working party was formed to review the content of existing data collections and their potential to meet cancer control information requirements relating to cancer patient treatment and outcomes. The need for a standard approach to data collection was identified as a first step to ensure that information about cancer treatment and care could be obtained easily and on a routine basis. The capacity to collect reliable, standardised national data sets is important for successful planning, evaluation, quality assurance and improvement of cancer control activities. One high priority project involved identifying data currently collected on cancer care, and obtaining consensus on what should be collected with a view to making recommendations on a national core clinical data set.

The Data Definition Working Party examined and refined the data definitions proposed by Professor Coates and formatted them according to the requirements for items in the National *Health Data Dictionary*. A draft dictionary was circulated for comment and the comments have now been incorporated into this supplement of the Dictionary.

Certain items included in this core data set are also collected by the population-based state cancer registries. Care has been taken to ensure that the definitions of these items are concordant with the draft data dictionary being developed by the Australasian Association of Cancer Registries and Australian Institute of Health and Welfare.

The Public Health Division of the NSW Department of Health has developed a Clinical Cancer Data Collection for New South Wales. Consistency between the NCCI and New

South Wales data sets has been maintained wherever practicable. Definitions sourced from the New South Wales data dictionary are indicated in the 'Source organisation' section of the Cancer DSS data elements.

Cancer (clinical) DSS

Admin. status:	CURRENT 04/06/2004	*Version number:*	1
Metadata type:	DATA SET SPECIFICATION		
Start date:	04/06/2004		

Scope:

This Cancer (clinical) data set specification is not mandated for collection but is recommended as best practice if cancer clinical data are to be collected.

The Cancer (clinical) data set underpins the evaluation of cancer treatment services and this can occur at a number of levels; the individual clinician, the health care institution, at state or territory level and ultimately at a national level.

Clinicians use such data for ongoing patient management and the ability to link patient management to outcomes allows treatments or outcomes to be identified and assessed. Institutions can monitor through-put in their centres for planning and resource allocation purposes to obtain optimum return for cancer expenditure. End-points can be monitored to ensure that objectives are being met.

The principal aim of good-quality and consistent data is to provide information that can lead to improved quality and length of life for all patients by providing a systematic foundation for evidence-based medicine, informing quality assurance and improvement decisions and guiding successful planning and evaluation of cancer control activities.

Collection methodology:

This data set is primarily concerned with the clinical use of cancer data. It can also be used by a wider range of health and health-related establishments that create, use, or maintain records on health-care clients.

Data elements included:

Address line, version 1♦...page 78

Cancer initial treatment — completion date, version 1♦ ....page 95

Cancer initial treatment — starting date, version 1♦........................page 97

Cancer staging — M stage code, version 1♦ ....page 99

Cancer staging — N stage code, version 1♦.....................................page 101

Cancer staging — T stage code, version 1♦ ....page 103

Cancer staging— TNM Stage grouping code, version 1♦.............page 105

Cancer treatment type, version 1♦ ....page 107

Cancer treatment — target site, version 1♦.....................................page 109

Date of birth, version 5♦...page 269

Date of death, version 1♦ ....page 127

Date of diagnosis of cancer, version 1♦...................... NHDD V12 page 164

Date of diagnosis of first recurrence, version 1♦............................page 128

Date of surgical treatment for cancer, version 1♦ ....page 133

Establishment number, version 4♦ ....page 278

Family name, version 2♦ ....page 283

Given name(s), version 2♦ ....page 288

♦ new in NMDS this version	∇ modified this version

***Scope links with other
metadata sets:***

Source organisation: National Cancer Control Initiative (NCCI).

Comments:

♦ new in NMDS this version   ∇ modified this version

Existing data set specifications

Data set specifications (DSS) are metadata sets that are not mandated for collection but are recommended as best practice. It is recommended that, if collecting data for the purposes of primary patient care, planning or analysis, the entire DSS be collected.

This *National Health Data Dictionary* Version 12 includes data items for the following data set specifications:

1   Cardiovascular disease (clinical)

2   Diabetes (clinical)

3   Health care client identification

Full descriptions of these data set specifications are found on the following pages.

Cardiovascular disease (clinical) DSS

Admin. status:	CURRENT 1/01/2003 Version number: 1
Metadata type:	DATA SET SPECIFICATION
Start date:	01/01/2003
Scope:	The collection of cardiovascular data (CV data) in this metadata set is voluntary.

The definitions used in CV data are designed to underpin the data collected by health professionals in their day-to-day practice. They relate to the realities of a clinical consultation and the ongoing nature of care and relationships that are formed between doctors and patients in clinical practice.

The data elements specified in this metadata set provide a framework for:

– promoting the delivery of high quality cardiovascular disease preventive and management care to patients;

– facilitating ongoing improvement in the quality of cardiovascular and chronic disease care predominantly in primary care and other community settings in Australia; and

– supporting general practice and other primary care services as they develop information systems to complement the above.

This is particularly important as general practice is the setting in which chronic disease prevention and management predominantly takes place. Having a nationally recognised set of definitions in relation to defining a patient's cardiovascular behavioural, social and biological risk factors, and their prevention and management status for use in these clinical settings, is a prerequisite to achieving these aims.

Many of the data elements in this metadata set are also used in the collection of diabetes clinical information.

Where appropriate, it may be useful if the data definitions in this metadata set were used to address data definition needs for use in non-clinical environments such as public health surveys etc. This could allow for qualitative comparisons between data collected in, and aggregated from, clinical settings (i.e. using application of CV data), with that collected through other means (e.g. public health surveys).

Collection methodology:	This metadata set is primarily concerned with the clinical use of CV data. It could also be used by a wider range of health and health-related establishments that create, use or maintain, records on health care clients.

Data elements included:

Alcohol consumption frequency – self report, version 1
....NHDD V12 page 44

Alcohol consumption in standard drinks per day – self report, version 1
....NHDD V12 page 47

Behaviour-related risk factor intervention, version 1
....NHDD V12 page 59

Behaviour-related risk factor intervention — purpose, version 1
....NHDD V12 page 61

Blood pressure — diastolic measured, version 1 ....NHDD V12 page 71

♦ new in NMDS this version   ∇ modified this version

♦ new in NMDS this version ∇ modified this version

Diabetes (clinical) DSS

Admin. status:	CURRENT 1/07/2002 Version number: 1
Metadata type:	DATA SET SPECIFICATION
Start date:	1 July 2002
Scope:	The use of this standard is voluntary.

However, if data is to be collected the Diabetes (clinical) DSS aims to ensure national consistency in relation to defining, monitoring and recording information on patients diagnosed with diabetes.

The Diabetes (clinical) DSS relates to the clinical status of, the provision of services for, and the quality of care delivered to individuals with diabetes, across all health care settings including:

- General practitioners
- Divisions of General Practice
- Diabetes centres
- Specialists in private practice
- Community health nurses and Diabetes educators.

The Diabetes (clinical) DSS:

- provides concise, unambiguous definitions for items/conditions related to diabetes quality care
- aims to ensure standardised methodology of data collection in Australia.

The expectation is that collection of this data set facilitates good quality of care, contributes to preventive care and has the potential to enhance self-management by patients with diabetes.

The underlying goal is improvement of the length and quality of life of patients with diabetes, and prevention or delay in the development of diabetes-related complications.

Collection methodology: This metadata set is primarily concerned with the clinical use of diabetes data. It could/should be used by health and health-related establishments that create, use or maintain, records on health care clients.

Data are collected over a 1-month period of all diabetes patients presenting at sites participating in the collection. The information is de-identified to protect the privacy of individuals. The participation is voluntary. An individual benchmarking report is provided. The results provide a snapshot of care of people with diabetes.

Data elements included: Blindness — diabetes complication, version 1 .... NHDD V12 page 68

Blood pressure — diastolic measured, version 1 .... NHDD V12 page 71

Blood pressure — systolic measured, version 1 .... NHDD V12 page 74

Cardiovascular medication — current, version 1 .... NHDD V12 page 92

Cataract — history, version 1 .... NHDD V12 page 100

Cerebral stroke due to vascular disease — history, version 1
.... NHDD V12 page 105

♦ new in NMDS this version   ∇ modified this version

♦ new in NMDS this version   ∇ modified this version

Data elements included (continued):	Sex, version 4$^{\nabla}$ .... page 365
	Tobacco smoking status — diabetes mellitus, version 1 .... NHDD V12 page 580
	Triglycerides — measured, version 1 .... NHDD V12 page 596
	Visual acuity, version 1 .... NHDD V12 page 625
	Weight — measured, version 2 .... NHDD V12 page 642
	Year insulin started, version 1 .... NHDD V12 page 648
	Year of diagnosis of diabetes mellitus, version 1 .... NHDD V12 page 650
Supporting data elements and data element concepts:	Blood pressure— concept, version 1 .... NHDD V12 page 70
	Service contact, version 11 .... NHDD V12 page 527
Scope links with other metadata sets:	Cardiovascular disease (clinical) DSS
Source organisation:	National Diabetes Data Working Group
Comments:	Statistical units are entities from or about which statistics are collected or in respect of which statistics are compiled, tabulated or published.

♦ new in NMDS this version   ∇ modified this version

Health care client identification DSS

Admin. status:	CURRENT 1/01/2003 Version number: 1
Metadata type:	DATA SET SPECIFICATIONS
Start date:	2003

Scope:

The collection of data based on this metadata set is voluntary.

The data elements specified in this metadata set provide a framework for improving the positive identification of persons in health care organisations.

This metadata set applies in respect of all potential or actual clients of the Australian health care system. It defines demographic and other identifying data elements suited to capture and use for person identification in health care settings.

The objectives in collecting the data elements in this metadata set are to promote uniformly good practice in:

– identifying individuals

– recording identifying data so as to ensure that each individual's health records will be associated with that individual and no other.

The process of positively identifying people within a health care service delivery context entails matching data supplied by those individuals against data the service provider holds about them.

The positive and unique identification of health care clients is a critical event in health service delivery, with direct implications for the safety and quality of health care.

There are many barriers to successfully identifying individuals in health care settings, including variable data quality; differing data capture requirements and mechanisms; and varying data matching methods. These definitions provide a base for improving the confidence of health service providers and clients alike that the data being associated with any given individual, and upon which clinical decisions are made, is appropriately associated.

Collection methodology:

This metadata set is primarily concerned with the clinical use of Health care client identification data. It should be used by health and health-related establishments that create, use or maintain, records on health care clients. Establishments should use this metadata set, where appropriate, for collecting data when registering health care clients or potential health care clients.

National reporting arrangements:

Collectors of this metadata set should refer to relevant privacy legislation, codes of fair information practice and other guidelines so as not to breach personal privacy in their collection, use, storage and disclosure of health care client information. There is no comprehensive privacy legislation covering both the public and private sectors across Australia so users need to consider their particular set of circumstances (i.e. location and sector) and whether privacy legislation covers those circumstances. A Commonwealth legislative scheme applies to the private sector. Users may refer to the Federal Privacy Commissioner's web site for assistance in complying with their privacy obligations. In the public sector, in instances where no legislation, code of fair information practice or other guidelines covers the particular circumstances, users should refer to AS 4400 Personal privacy protection in health care information systems.

National reporting arrangements (continued):	Public sector agencies should refer to relevant legislation and regulations pertaining to state and territory records so as not to breach their obligations regarding the creation and retention of public records.

Supporting data elements and data element concepts (continued):	Name, version 1 ....NHDD V12 page 366
	Postal delivery service number, version 1♦...page 190
	Postal delivery service type — abbreviation, version 1♦......................page 192
	Street name, version 1♦ ....page 226
	Street suffix code, version 1♦...page 228
	Street type code, version 1♦ page 230
Scope links with other metadata sets:	Collection of information in national minimum data sets.
Source organisation:	Standards Australia Inc.

♦ new in NMDS this version   ∇ modified this version

New data elements

During the year, the Health Data Standards Committee considered many submissions for new data standards for inclusion in the *National Health Data Dictionary*. This is not a static environment and there is much work being undertaken. As a deliberative committee, the HDSC approved the following data elements for inclusion in the Version 12 Supplement of the *National Health Data Dictionary*. All data items listed were approved by the Health Data Standards Committee and the National Health Information Group. Data items which were part of a National Minimum Data Set were also approved by the Statistical Information Management Committee.

Acute coronary syndrome (clinical) data set specification

A standardised nationally recognised core set of data items was created for the clinical management of patients presenting with acute coronary syndromes in order to improve the quality and safety of care for these patients and consequently, their health outcomes. The resulting data set will facilitate outcomes research and improve the epidemiological and public health understanding of acute coronary syndromes. The following data items were created:

- Acute coronary procedures procedure type
- Acute coronary syndrome stratum
- Angiotensin converting enzyme (ACE) inhibitors therapy status
- Aspirin therapy status
- Beta-blocker therapy status
- Bleeding episode using TIMI criteria — status
- Chest pain pattern category
- Clinical evidence status
- Clinical procedures timing status
- Clopidogrel therapy status
- Concurrent clinical condition — on presentation
- Creatine kinase MB isoenzyme (CK-MB) — measured
- Creatine kinase MB isoenzyme (CK-MB) — units
- Creatine kinase MB isoenzyme (CK-MB) — upper limit of normal range
- Date creatine kinase isoenzyme MB (CK-MB) — measured
- Date of first angioplasty balloon inflation or stenting

- Date of intravenous fibrinolytic therapy
- Date troponin measured
- Electrocardiogram (ECG) change — location
- Electrocardiogram (ECG) change — type
- Fibrinolytic drug used
- Fibrinolytic therapy status
- Functional stress test element
- Functional stress test ischaemic result
- Glycoprotein IIb/IIIa receptor antagonist status
- Heart rate
- Heart rhythm type
- Killip classification code
- Lipid-lowering therapy status
- Reason for readmission — acute coronary syndrome
- Time creatine kinase MB isoenzyme (CK-MB) measured
- Time of first angioplasty balloon inflation or stenting
- Time of intravenous fibrinolytic therapy

– Time troponin measured

– Troponin assay type

– Troponin assay — upper limit of normal range

– Troponin measured

Address data items

Several new address related data elements have been introduced, that enable the detailed description of a location/site:

– Address line

– Building/complex sub-unit number

– Building/complex sub-unit type — abbreviation

– Building/property name

– Floor/level number

– Floor/level type

– House/property number

– Lot/section number

– Postal delivery service type — abbreviation

– Postal delivery service number

– Street name

– Street suffix code

– Street type code

Cancer (clinical) data set specification

A standardised nationally recognised core set of data items was created for the collection of variables that would enable national patterns of cancer survival by stage at diagnosis or cancer patient management to be assessed. As a result, the following data items were created:

– Cancer initial treatment — completion date,

– Cancer initial treatment — starting date,

– Cancer staging — M stage code

– Cancer staging — N stage code

– Cancer staging — T stage code

– Cancer staging — TNM stage grouping code

– Cancer treatment type

– Cancer treatment — target site

– Date of death

– Date of diagnosis of first recurrence

– Date of surgical treatment for cancer

– Histopathological grade

– Initial treatment episode for cancer

– Intention of treatment for cancer

– Most valid basis of diagnosis of cancer

– Oestrogen receptor assay status

– Outcome of initial treatment

– Progesterone receptor assay status

– Radiotherapy treatment given

– Received radiation dose

– Region of first recurrence

– Regional lymph nodes examined

– Regional lymph nodes positive

– Staging basis

– Staging scheme source

– Staging scheme source edition number

– Surgical treatment procedure for cancer

– Systemic therapy agent name

Cancer registries

The introduction of additional cancer registries data elements:

–   Degree of spread of cancer

–   Most valid basis of diagnosis of cancer

Community mental health establishments NMDS

The introduction of an additional data element due to identified deficiencies in the Community mental health establishments NMDS:

–   Specialised mental health service setting

Residential mental health care NMDS

To help understand the care provided by residential mental health care services several new data items have been developed for the new Residential mental health care NMDS:

–   Episode of residential care

–   Episode of residential care end

–   Episode of residential care end date

–   Episode of residential care end mode

–   Episode of residential care start

–   Episode of residential care start date

–   Episode of residential care start mode

–   Leave days from residential care

–   Referral from specialised mental health residential care

–   Resident

–   Residential mental health service

–   Residential stay

–   Residential stay start date

–   Specialised mental health service

Specialist private sector rehabilitation care indicator:

–   Specialist private sector rehabilitation care indicator

Acute coronary syndrome procedure type

Identifying and definitional attributes

Knowledgebase ID: **001019**   ***Version number:***   **1**

Metadata type: Data element

Definition:	The type of procedure performed, that is pertinent to the treatment of acute coronary syndrome.
Context:	Acute coronary syndrome treatment settings.

Relational and representational attributes

Data type: Numeric   ***Maximum field size:***   2

Representational class: Code   ***Format:***   NN

Data domain:	01	coronary artery bypass graft (CABG)
	02	coronary stent (bare metal)
	03	coronary stent (drug eluding)
	04	angioplasty
	05	reperfusion fibrinolytic therapy
	06	reperfusion primary percutaneous coronary intervention (PCI)
	07	rescue angioplasty/stenting
	08	vascular reconstruction, bypass surgery, or percutaneous intervention to the extremities or for aortic aneurysm
	09	amputation for arterial vascular insufficiency
	10	diagnostic cardiac catheterisation/angiography
	11	blood transfusion
	12	insertion of pacemaker
	13	implantable cardiac defibrillator
	14	intra-aortic balloon pump (IABP)
	17	defibrillation
	88	other
	99	not stated/inadequately described

Guide for use:	More than one procedure may be recorded.
	Record only those codes that apply.
	Record all codes that apply.
	When read in conjunction with Clinical procedure timing status, this data element provides information on the procedure(s) provided to a patient prior to or during admission.
	When read in conjunction with Acute coronary syndrome stratum, codes 01 to 10 of this data element provide information for risk stratification.
Verification rules:	Codes 88 and 99 cannot be used in multiple entries.

Collection methods:	At admission, each procedure performed for the treatment of acute coronary syndrome prior to that admission should be recorded in conjunction with the data element Clinical procedure timing status (i.e. code 1).
	Each procedure performed for the treatment of acute coronary syndrome during the episode of admitted patient care should also be recorded in conjunction with the data element Clinical procedure timing status (i.e. code 2).
Related metadata:	Is used in conjunction with the data element Clinical procedure timing status, version 1.
	Is used in conjunction with the data element Acute coronary syndrome stratum, version 1.
Information model link:	NHIM Acute event

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

Administrative attributes

Admin. status:	CURRENT	*Effective Date:*	04/06/2004
Source organisation:	Acute Coronary Syndrome Data Working Group.		
Source document:			
Registration authority:	National Health Information Group.		
Steward:			
Comments:			

Acute coronary syndrome stratum

Identifying and definitional attributes

Knowledgebase ID:	*001021*	*Version number:*	*1*
Metadata type:	Data element		

Definition:	Risk stratum of the patient presenting with clinical features consistent with an acute coronary syndrome (chest pain or overwhelming shortness of breath (SOB)) defined by accompanying clinical, electrocardiogram (ECG) and biochemical features.
Context:	Health care and clinical settings.
	The clinical, electrocardiogram and biochemical characteristics are important to enable early risk stratification.

Relational and representational attributes

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

Data domain:	1	with ST elevation (myocardial infarction)
	2	with non-ST elevation ACS with high-risk features
	3	with non-ST elevation ACS with intermediate-risk features
	4	with non-ST elevation ACS with low-risk features
	9	not reported

Guide for use: Code 1   with ST elevation (myocardial infarction), used where persistent ST elevation of ≥1mm in two contiguous limb leads, or ST elevation of ≥2mm in two contiguous chest leads, or with left bundle branch block (BBB) pattern on the ECG.

This classification is intended for identification of patients potentially eligible for reperfusion therapy, either pharmacologic or catheter-based. Other considerations such as the time to presentation and the clinical appropriateness of instituting reperfusion are not reflected in this data element.

Code 2   with non-ST elevation ACS with high-risk features, used when presentation with clinical features consistent with an acute coronary syndrome (chest pain or overwhelming SOB) with high-risk features which include either:

– classical rise and fall of at least one cardiac biomarker (troponin or CK-MB),

– persistent or dynamic ECG changes of ST segment depression ≥ 0.5mm or new T wave inversion in three or more contiguous leads,

– transient (< 20 minutes) ST segment elevation (≥ 0.5 mm) in more than 2 contiguous leads,

– haemodynamic compromise: Blood pressure < 90 mm Hg systolic, cool peripheries, diaphoresis, Killip Class > 1, and/or new onset mitral regurgitation, and/or syncope, or

>   –   presence of known diabetes without persistent ST elevation of > 1mm in two or more contiguous leads or new or presumed new bundle branch block (BBB) pattern on the initial ECG, i.e. not meeting the definition for ST elevation MI.
>
>   This classification is intended for identification of patients potentially eligible for early invasive management and the use of intravenous glycoprotein IIb/IIIa receptor antagonist.

Code 3 with non-ST elevation ACS with intermediate-risk features, used when presentation with clinical features consistent with an acute coronary syndrome (chest pain or overwhelming SOB) with intermediate-risk features which include either:

>   –   prolonged but resolved chest pain/discomfort at rest < 48 hours;
>
>   –   age greater than 65 yrs;
>
>   –   known coronary heart disease: prior MI, prior revascularisation, known coronary lesion > 50%;
>
>   –   pathological Q waves or ECG changes of ST deviation < 0.5mm or minor T wave inversion in less than 3 contiguous leads;
>
>   –   nocturnal pain;
>
>   –   two or more risk factors of known hypertension, family history, active smoking or hyperlipidaemia or;
>
>   –   prior aspirin use and not meeting the definition for ST elevation MI or Non-ST elevation with high-risk features.

This classification is intended for identification of patients potentially eligible for admission and in-hospital investigation that may or may not include angiography.

Code 4 with non-ST elevation ACS with low-risk features, used when presentation with clinical features consistent with an acute coronary syndrome (chest pain or overwhelming SOB) without features of ST elevation MI or Non-ST elevation ACS with intermediate or high-risk features.

This classification is intended for identification of patients potentially eligible for outpatient investigation.

Other clinical considerations influencing the decision to admit and investigate are not reflected in this data element. This data element is intended to simply provide a diagnostic classification at the time of, or within hours of clinical presentation.

Verification rules:

Collection methods: Collected at time of presentation.

Only one code should be recorded.

Related metadata: Is qualified by Creatine kinase MB isoenzyme (CK-MB) measured, version 1.

Is qualified by Chest pain pattern category, version 1.

Is qualified by Concurrent clinical condition — on presentation, version 1.

Is qualified by Electrocardiogram (ECG) change — type, version 1.

Is qualified by Functional stress test ischaemic result, version 1.

Is qualified by Killip classification code, version 1.

Is used in conjunction with Acute coronary syndrome procedure type, version 1.

Is used in conjunction with Clinical procedure timing status, version 1.

Is a qualifier of Reason for readmission — Acute coronary syndrome, version 1.

Is qualified by Troponin measured, version 1.

Information model link: NHIM   Acute event

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

Administrative attributes

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

Source organisation: Acute Coronary Syndrome Data Working Group.

Source document: *Management of Unstable Angina Guidelines – 2000*, The National Heart Foundation of Australia, The Cardiac Society of Australia and New Zealand MJA, 173 (Supplement) S65–S88 Antman, MD; et al.

The TIMI Risk Score for Unstable Angina/Non–ST Elevation MI JAMA. 2000; 284:835–842.

Registration authority: National Health Information Group.

Steward: The National Heart Foundation of Australia.

The Cardiac Society of Australia and New Zealand.

Comments:

Address line

Identifying and definitional attributes

Knowledgebase ID: **000786** ***Version number:*** **1**

Metadata type: Data element

Definition:	A composite of one or more standard address components that describes a low level of geographical/physical description of a location that, used in conjunction with the other high-level address components i.e. Suburb/town/locality name, Postcode — Australian, Australian state/territory, and Country, forms a complete geographical/physical Address.
Context:	

Relational and representational attributes

Data type: Alphanumeric ***Maximum field size:*** 180

Representational class: Text ***Format:*** AN(180)

Data domain:	A composite of one or more standard address components.

Guide for use:	When addressing an Australian location, following are the standard address data elements that may be concatenated in the Address line:

- Building/complex sub-unit type — abbreviation
- Building/complex sub-unit number
- Building/property name
- Floor/level number
- Floor/level type
- House/property number
- Lot/section number
- Street name
- Street type code
- Street suffix code

One complete identification/description of a location/site of an address can comprise one or more than one instance of Address line.

Instances of address lines are commonly identified in electronic information systems as Address-line 1, Address-line 2, etc.

The format of data collection is less important than consistent use of conventions in the recording of address data. Hence, address may be collected in an unstructured manner but should ideally be stored in a structured format.

Where Address line is collected as a stand-alone item, software may be used to parse the Address line details to separate the sub-components.

Multiple Address lines may be recorded as required.

Verification rules:

Collection methods: The following concatenation rules should be observed when collecting address lines addressing an Australian location.

- Building/complex sub-unit type is to be collected in conjunction with Building/complex sub-unit number and vice versa.

- Floor/level type is to be collected in conjunction with Floor/level number and vice versa.

- Street name is to be used in conjunction with Street type code and Street suffix code.

- Street type code is to be used in conjunction with Street name and Street suffix code.

- Street suffix code is to be used in conjunction with Street name and Street type code.

- House/property number is to be used in conjunction with Street name.

Related metadata: Relates to the data element concept Address, version 2.

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

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 Postcode — Australian, version 3.

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 Suburb/town/locality name, version 2.

Information model link: NHIM   Address element

Data set specifications:	*Start date*	*End date*
DSS — Cancer (clinical)	04/06/2004	
DSS — Health care client identification	25/02/2004	

Administrative attributes

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

Source organisation: Standards Australia.

Health Data Standards Committee.

Source document: AS 5017 Health Care Client Identification.

Registration authority: National Health Information Group.

Steward: Health Data Standards Committee.

Comments:

Angiotensin converting enzyme (ACE) inhibitors therapy status

Identifying and definitional attributes

Knowledgebase ID:	**001020**	*Version number:*	**1**
Metadata type:	Data element		

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

Relational and representational attributes

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

Data domain:	10	Given
	21	Not given — patient refusal
	22	Not given — allergy or intolerance (e.g. cough) to ACE inhibitors
	23	Not given — moderate to severe aortic stenosis
	24	Not given — bilateral renal artery stenosis
	25	Not given — history of angio-oedema, hives, or rash in response to ACE inhibitors
	26	Not given — hyperkalaemia
	27	Not given — symptomatic hypotension
	28	Not given — severe renal dysfunction
	29	Not given — other
	90	Not stated/inadequately described

Guide for use:	If recording 'Not given', record the principal reason if more than one code applies.
Verification rules:	
Collection methods:	For Acute coronary syndrome (ACS) reporting, can be collected at any time point during the management of the current event (i.e. at the time of triage, at times during the admission, or at the time of discharge).
Related metadata:	
Information model link:	NHIM Physical wellbeing

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

Administrative attributes

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

Source organisation: Acute Coronary Syndrome Data Working Group.

Source document:

Registration authority: National Health Information Group.

Steward: National Heart Foundation of Australia.

Coronary Syndromes of Australian and New Zealand.

Comments:

Aspirin therapy status

Identifying and definitional attributes

Knowledgebase ID:	**001022**	*Version number:*	**1**
Metadata type:	Data element		

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

Relational and representational attributes

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

Data domain:	10	Given
	21	Not given — patient refusal
	22	Not given — true allergy to aspirin
	23	Not given — active bleeding
	24	Not given — bleeding risk
	29	Not given — other
	90	Not stated/inadequately described

Guide for use:	If recording 'Not given', record the principal reason if more than one code applies.
Verification rules:	
Collection methods:	For Acute coronary syndrome (ACS) reporting, can be collected at any time point during the management of the current event (i.e. at the time of triage, at times during the admission, or at the time of discharge).
Related metadata:	
Information model link:	NHIM Physical wellbeing

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

Administrative attributes

Admin. status:	CURRENT	*Effective Date:*	04/06/2004
Source organisation:	Acute Coronary Syndrome Data Working Group.		
Source document:			
Registration authority:	National Health Information Group.		

Steward: The National Heart Foundation of Australia.

                                    The Cardiac Society of Australia and New Zealand.

Comments:

Beta-blocker therapy status

Identifying and definitional attributes

Knowledgebase ID: **001023**   *Version number:*   **1**

Metadata type: Data element

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

Relational and representational attributes

Data type: Numeric   *Maximum field size:*   2

Representational class: Code   *Format:*   NN

Data domain:	10	Given
	21	Not given – Patient refusal
	22	Not given — Allergy or history of intolerance
	23	Not given — Bradycardia (heart rate less than 50 beats per minute)
	24	Not given — Symptomatic acute heart failure
	25	Not given — Systolic blood pressure of less than 90 mmHg
	26	Not given — PR interval greater than 0.24 seconds
	27	Not given — 2nd- and 3rd-degree heart block or bifascicular heart block
	28	Not given – Asthma/Airways hyper-reactivity
	29	Not given — other
	90	Not stated/inadequately described

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

Verification rules:

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

Related metadata:

Information model link: NHIM   Physical wellbeing

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

Administrative attributes

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

Source organisation: Acute Coronary Syndrome Data Working Group.

Source document:

Registration authority: National Health Information Group.

Steward: The National Heart Foundation of Australia.

The Cardiac Society of Australia and New Zealand.

Comments:

Bleeding episode using TIMI criteria — status

Identifying and definitional attributes

Knowledgebase ID: **001024**   *Version number:*   **1**

Metadata type: Data element

Definition:	A person's episode of bleeding as described by the Thrombolysis In Myocardial Infarction (TIMI) criteria.
Context:	Health care and clinical settings.

Relational and representational attributes

Data type: Numeric   *Maximum field size:*   1

Representational class: Code   *Format:*   N

Data domain:	1	Major
	2	Minor
	3	Non TIMI bleeding
	4	None
	9	Not stated/inadequately described

Guide for use: Code 1   Major. Overt clinical bleeding (or documented intracranial or retroperitoneal haemorrhage) associated with a drop in haemoglobin of greater than 5g/dl (0.5g/l) or a haematocrit of greater than 15% (absolute).

Code 2   Minor. Overt clinical bleeding associated with a fall in haemoglobin of 3 or less than or equal to 5g/dl (0.5g/l) or a haematocrit of 9% to less than or equal to 15% (absolute).

Code 3   Non TIMI bleeding. Bleeding event that does not meet the major or minor definition.

Code 4   None: No bleeding event.

Note in calculating the fall in haemoglobin or haematocrit, transfusion of whole blood or packed red blood cells is counted as 1g/dl (0.1g/l) haemoglobin or 3% absolute haematocrit.

Acute coronary syndrome DSS:

Can be collected at any time point during the management of the current event (i.e. at the time of triage, at times during the admission, or at the time of discharge).

Verification rules:

Collection methods:

Related metadata: Is used in conjunction with Acute coronary syndrome procedure type, version 1.

Information model link: NHIM   Physical wellbeing

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

Administrative attributes

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

Source organisation: Acute Coronary Syndrome Data Working Group.

Source document: *Thrombolysis in Myocardial Infarction (TIMI) Trial, phase I: hemorrhagic manifestations and changes in plasma fibrinogen and the fibrinolytic system in patients with recombinant tissue plasminogen activator and streptokinase.*
J Am Coll Cardiol 1988; 11:1–11.

Registration authority: National Health Information Group.

Steward: The National Heart Foundation of Australia.

The Cardiac Society of Australia and New Zealand.

Comments:

Building/complex sub-unit number

Identifying and definitional attributes

Knowledge base ID:	**001007**	*Version number:*	**1**
Metadata type:	Data element		

Definition:	The specification of the number or identifier of a building/complex, marina, etc. to clearly distinguish it from another.
Context:	Australian addresses.

Relational and representational attributes

Data type:	Alphanumeric	*Maximum field size:*	7
Representational class:	Text	*Format:*	AN(7)

Data domain:

Guide for use:	The Building/complex sub-unit number must be recorded with its corresponding Building/complex sub-unit type — abbreviation.
	Where applicable, the number may be followed by an alphanumeric suffix.
	Examples:
	APT 6
	SHOP 3A
	U 6
Verification rules:	
Collection methods:	To be collected in conjunction with Building/complex sub-unit type — abbreviation.
	Where a building or other type of unit is present in a complex of such buildings or units, the data elements Building/unit sub-unit type — abbreviation and Building/complex sub-unit number should be used in conjunction in that order. An example can be seen in a shop within a shopping complex. Such a shop could have as part of its address line the word 'shop' as the type followed by its identifying 'number' within the complex, e.g. '209a'. Thus the words 'Shop 209a' would form part of the Address line.
Related metadata:	Relates to the data element Building/complex sub-unit type — abbreviation, version 1.
	Is a composite part of the data element Address line, version 1.
Information model link:	NHIM Address element

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

Administrative attributes

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

Source organisation: Health Data Standards Committee.

Source document: Australia Post Address Presentation Standard.

Registration authority: National Health Information Group.

Steward: Health Data Standards Committee.

Comments:

Building/complex sub-unit type — abbreviation

Identifying and definitional attributes

Knowledgebase ID: *001008*   *Version number:*   *1*

Metadata type: Data element

Definition:	The specification of the type of a separately identifiable portion within a building/complex, marina, etc. to clearly distinguish it from another.
Context:	Australian addresses.

Relational and representational attributes

Data type: Alphabetic   *Maximum field size:*   4

Representational class: Code   *Format:*   A(4)

Data domain:	APT	Apartment
	CTGE	Cottage
	DUP	Duplex
	FY	Factory
	F	Flat
	HSE	House
	KSK	Kiosk
	MSNT	Maisonette
	MB	Marine Berth
	OFF	Office
	PTHS	Penthouse
	RM	Room
	SHED	Shed
	SHOP	Shop
	SITE	Site
	SL	Stall
	WARD	Ward
	WE	Warehouse

Guide for use: Addresses may contain multiple instances of Building /Complex Type. Record each instance of Building/Complex Type with its corresponding Building/Complex Number when appropriate.

Examples:

APT 6

SHOP 3A

U 6

Verification rules:

Collection methods: To be collected in conjunction with Building/complex sub-unit number.

Related metadata:	Relates to the data element Building/complex sub-unit number, version 1.
	Is a composite part of the data element Address line, version 1.

Information model link:	NHIM	Address element

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

Administrative attributes

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

Building/property name

Identifying and definitional attributes

Knowledgebase ID:	**001009**	*Version number:*	**1**
Metadata type:	Data element		

Definition:	The full name used to identify the physical building or property as part of its location.
Context:	Australian addresses.

Relational and representational attributes

Data type:	Alphanumeric	*Maximum field size:*	30
Representational class:	Text	*Format:*	AN(30)

Data domain:	Valid alphanumeric characters.

Guide for use:	Usually this information is not abbreviated.
	Should include any reference to a wing or other components of a building complex, if applicable.
	A comma is to be used to separate the wing reference from the rest of the building name.
	Record each Building/property name relevant to the address:
	– Building/property name 1 (30 alphanumeric characters)
	– Building/property name 2 (30 alphanumeric characters)
	For example:
	Building — TREASURY BUILDING
	Property — BRINDABELLA STATION
Verification rules:	
Collection methods:	
Related metadata:	Is a composite part of the data element Address line, version 1.
Information model link:	NHIM Address element

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

Administrative attributes

Admin. status:	CURRENT	*Effective Date:*	25/02/2004
Source organisation:	Health Data Standards Committee.		
Source document:	Australia Post Address Presentation Standard.		

Registration authority: National Health Information Group.

Steward: Health Data Standards Committee.

Comments:

Cancer initial treatment — completion date

Identifying and definitional attributes

Knowledgebase ID:	**001055**	*Version number:*	**1**
Metadata type:	Data element		

Definition:	The date on which the initial non-surgical treatment for cancer was completed.
Context:	This item is collected for the analysis of outcome by treatment type.
	Collected for radiation therapy and systemic therapy.
	Collecting dates for radiotherapy treatment and systemic therapy agent treatment will allow evaluation of treatments delivered and of time intervals from diagnosis to treatment, from treatment to recurrence and from treatment to death.

Relational and representational attributes

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

Data domain:	Valid date.

Guide for use:	
Verification rules:	This field must:
	– be greater than or equal to Date of diagnosis of cancer
	– be greater than or equal to Cancer initial treatment — starting date
Collection methods:	
Related metadata:	Relates to the data element concept Initial treatment episode for cancer, version 1.
	Relates to the data element Radiotherapy treatment given, version 1.
	Relates to the data element Systemic therapy agent name, version 1.
	Relates to the data element Cancer initial treatment — starting date, version 1.
Information model link:	NHIM Exit/leave from service event

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

Administrative attributes

Admin. status:	CURRENT	*Effective Date:*	04/06/2004
Source organisation:	Commission on Cancer, American College of Surgeons.		

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

Registration authority: National Health Information Group.

Steward:

Comments:

Cancer initial treatment — starting date

Identifying and definitional attributes

Knowledgebase ID: **001056**   *Version number:*   *1*

Metadata type: Data element

Definition:	The start date of the initial course of non-surgical treatment for cancer.
Context:	This item is collected for the analysis of outcome by treatment type.
	Collected for radiation therapy and systemic therapy.
	Collecting dates for radiotherapy treatment and systemic therapy agent treatment will allow evaluation of treatments delivered and of time intervals from diagnosis to treatment, from treatment to recurrence and from treatment to death. Date of surgical treatment is collected as a separate item.

Relational and representational attributes

Data type: Numeric   *Maximum field size:*   8

Representational class: Date   *Format:*   DDMMYYYY

Data domain:	Valid date.

Guide for use: The start date of the treatment is recorded regardless of whether it is completed as intended or not. Treatment subsequent to a recurrence will not be recorded.

Verification rules: This field must:

–   be greater than or equal to Date of diagnosis of cancer

–   be less than or equal to Cancer initial treatment — completion date

Collection methods:

Related metadata: Relates to the data element Radiotherapy treatment given, version 1.

Relates to the data element Systemic therapy agent name, version 1.

Relates to the data element Date of diagnosis of cancer, version 1.

Relates to the data element Cancer initial treatment — completion date, version 1.

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

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

Administrative attributes

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

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

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

Registration authority: National Health Information Group.

Steward:

Comments:

Cancer staging — M stage code

Identifying and definitional attributes

Knowledgebase ID:	***001057***	*Version number:*	***1***
Metadata type:	Data element		

Definition:	M stage is the coding system used to record the absence or presence of distant metastases at the time of diagnosis of the primary cancer. It is part of the TNM cancer staging system.
Context:	For survival analysis adjusted by stage at diagnosis and distribution of cancer cases by type and stage.

Relational and representational attributes

Data type:	Alphanumeric	*Maximum field size:*	3
Representational class:	Code	*Format:*	AAA

Data domain:	Valid M codes from the current edition of the *UICC TNM Classification of Malignant Tumours.*
	88 Not applicable

Guide for use:	Refer to the UICC reference manual, *TNM Classification of Malignant Tumours* for coding rules.
	Choose the lower (less advanced) M category when there is any uncertainty.
Verification rules:	
Collection methods:	From information provided by the treating doctor and recorded on the patient's medical record.
Related metadata:	Relates to the data element Cancer staging — T stage code, version 1.
	Relates to the data element Cancer staging — N stage code, version 1.
	Relates to the data element Staging basis, version 1.
	Relates to the data element Cancer staging — TNM stage grouping code, version 1.
	Relates to the data element Staging scheme source, version 1.
	Relates to the data element Staging scheme edition number, version 1.
Information model link:	NHIM Physical wellbeing

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

Administrative attributes

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

Source organisation: International Union Against Cancer (UICC).

Commission on Cancer, American College of Surgeons.

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

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

Registration authority: National Health Information Group.

Steward:

Comments: Cancer prognosis and survival can be related to the extent of the disease at diagnosis. Survival rates are generally higher if the disease is localised to the organ of origin compared with cases in which the tumour has spread beyond the primary site. Staging systems seek to classify patients having a similar prognosis into groups or stages. TNM staging is an internationally agreed staging classification system based on the anatomical site of the primary tumour and its extent of spread. The T component refers to the size of the tumour and whether or not it has spread to surrounding tissues. The N component describes the presence or absence of tumour in regional lymph nodes. The M component refers to the presence or absence of tumour at sites distant from the primary site.

TNM staging applies to solid tumours excluding brain tumours.

Cancer staging — N stage code

Identifying and definitional attributes

Knowledgebase ID: **001058**   *Version number:*   **1**

Metadata type: Data element

Definition:	N stage is the coding system used to denote the absence or presence of regional lymph node metastases. It classifies the extent of regional lymph node metastases at the time of diagnosis of the primary cancer. It is a part of the TNM cancer staging system.
Context:	For survival analysis adjusted by stage at diagnosis and distribution of cancer cases by type and stage.

Relational and representational attributes

Data type: Alphanumeric   *Maximum field size:*   3

Representational class: Code   *Format:*   AAA

Data domain:	Valid N codes from the current edition of the *UICC TNM Classification of Malignant Tumours.* 88 Not applicable

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

Choose the lower (less advanced) N category when there is any uncertainty.

Verification rules:

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

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

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

Relates to the data element Staging basis, version 1.

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

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

Relates to the data element Staging scheme edition number, version 1.

Information model link: NHIM   Physical wellbeing

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

   DSS — Cancer (clinical)   04/06/2004

Administrative attributes

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

Source organisation: International Union Against Cancer (UICC).

Commission on Cancer, American College of Surgeons.

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

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

Registration authority: National Health Information Group.

Steward:

Comments: Cancer prognosis and survival can be related to the extent of the disease at diagnosis. Survival rates are generally higher if the disease is localised to the organ of origin compared with cases in which the tumour has spread beyond the primary site. Staging systems seek to classify patients having a similar prognosis into groups or stages. TNM staging is an internationally agreed staging classification system based on the anatomical site of the primary tumour and its extent of spread. The T component refers to the size of the tumour and whether or not it has spread to surrounding tissues. The N component describes the presence or absence of tumour in regional lymph nodes. The M component refers to the presence or absence of tumour at sites distant from the primary site.

TNM staging applies to solid tumours excluding brain tumours.

Cancer staging — T stage code

Identifying and definitional attributes

Knowledgebase ID: **001059**   *Version number:*   **1**

Metadata type: Data element

Definition:	T stage is the coding system used to identify the presence the primary tumour. It reflects the tumour size and extent of the primary cancer at the time of diagnosis. It is a part of the TNM cancer staging system.
Context:	For survival analysis adjusted by stage at diagnosis and distribution of cancer cases by type and stage.

Relational and representational attributes

Data type: Alphanumeric   *Maximum field size:*   3

Representational class: Code   *Format:*   AAA

Data domain:	Valid T codes from the current edition of the *UICC TNM Classification of Malignant Tumours*.
	88 Not applicable

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

Choose the lower (less advanced) T category when there is any uncertainty.

Verification rules:

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

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

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

Relates to the data element Staging basis, version 1.

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

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

Relates to the data element Staging scheme edition number, version 1.

Information model link: NHIM   Physical wellbeing

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

Administrative attributes

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

Source organisation: International Union Against Cancer (UICC).

Commission on Cancer, American College of Surgeons.

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

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

Registration authority: National Health Information Group.

Steward:

Comments: Cancer prognosis and survival can be related to the extent of the disease at diagnosis. Survival rates are generally higher if the disease is localised to the organ of origin compared with cases in which the tumour has spread beyond the primary site. Staging systems seek to classify patients having a similar prognosis into groups or stages. TNM staging is an internationally agreed staging classification system based on the anatomical site of the primary tumour and its extent of spread. The T component refers to the size of the tumour and whether or not it has spread to surrounding tissues. The N component describes the presence or absence of tumour in regional lymph nodes. The M component refers to the presence or absence of tumour at sites distant from the primary site.

TNM staging applies to solid tumours excluding brain tumours.

Cancer staging — TNM stage grouping code

Identifying and definitional attributes

Knowledgebase ID:	***001060***	*Version number:*	***1***
Metadata type:	Data element		

Definition:	The stage grouping defines the anatomical extent of disease at diagnosis based on the previously coded T, N and M stage categories.
Context:	For survival analysis adjusted by stage at diagnosis and distribution of cancer cases by type and stage.

Relational and representational attributes

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

Data domain:	Valid stage grouping codes from the current edition of the UICC TNM Classification of Malignant Tumours.
	8888 Not applicable
	9999 Unknown, Stage X

Guide for use:	Refer to the UICC reference manual *TNM Classification of Malignant Tumours* for coding rules.
	Choose the lower (less advanced) stage grouping when there is any uncertainty.
Verification rules:	
Collection methods:	From information provided by the treating doctor and recorded on the patient's medical record.
Related metadata:	Relates to the data element Cancer staging — T stage code, version 1.
	Relates to the data element Cancer staging — N stage code, version 1.
	Relates to the data element Cancer staging — M stage code, version 1.
	Relates to the data element Staging basis, version 1.
	Relates to the data element Staging scheme source, version 1.
	Relates to the data element Staging scheme edition number, version 1.
Information model link:	NHIM Physical wellbeing

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

Administrative attributes

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

Source organisation: International Union Against Cancer (UICC).

Commission on Cancer, American College of Surgeons.

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

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

Registration authority: National Health Information Group.

Steward:

Comments:

Cancer treatment type

Identifying and definitional attributes

Knowledgebase ID:	**001061**	*Version number:*	**1**
Metadata type:	Data element		

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

Relational and representational attributes

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

Data domain:	0	No treatment
	1	Surgical treatment
	2	Radiation therapy
	3	Systemic agent therapy
	4	Surgical and radiation treatment
	5	Surgical treatment and systemic agent treatment
	6	Radiation and systemic agent treatment
	7	All three treatment types

Guide for use:

Verification rules:

Collection methods:

Related metadata:	Relates to the data element concept Initial treatment episode for cancer, version 1.
	Relates to the data element Intention of treatment for cancer, version 1.
	Relates to the data element Surgical treatment procedure for cancer, version 1.
	Relates to the data element Date of surgical treatment for cancer, version 1.
	Relates to the data element Radiotherapy treatment given, version 1.
	Relates to the data element Systemic therapy agent name, version 1.
	Relates to the data element Cancer initial treatment — starting date, version 1.
	Relates to the data element Cancer initial treatment — completion date, version 1.
Information model link:	NHIM Exit/leave from service event

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

Administrative attributes

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

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

New South Wales Health Department.

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

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

Registration authority: National Health Information Group.

Steward:

Comments:

Cancer treatment — target site

Identifying and definitional attributes

Knowledgebase ID: **001062**   *Version number:*   **1**

Metadata type: Data element

Definition:	The site or region of cancer which is the target of a particular surgical or radiotherapy treatment.
Context:	This information is collected for surgical and radiotherapy treatments.

Relational and representational attributes

Data type: Alphanumeric   *Maximum field size:*   3

Representational class: Code   *Format:*   ANN

Data domain:	Current edition of ICD–O topography codes (Major organ only — first 3 characters).
	Current edition of ICD–10–AM.

Guide for use:

Verification rules:

Collection methods:

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

Information model link: NHIM   Physical wellbeing

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

Administrative attributes

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

Source organisation: World Health Organization

Source document: Current edition of *International Classification of Diseases for Oncology* (ICD–O), World Health Organization.

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

Registration authority: National Health Information Group.

Steward:

Comments:

Chest pain pattern category

Identifying and definitional attributes

Knowledgebase ID: **001025**   *Version number:*   *1*

Metadata type: Date element

Definition:	Describes the person's chest pain pattern.
Context:	Health care and clinical settings.

Relational and representational attributes

Data type: Numeric   *Maximum field size:*   1

Representational class: Code   *Format:*   N

Data domain:	1	Atypical chest pain
	2	Stable chest pain pattern
	3	Unstable chest pain pattern: rest &/or prolonged
	4	Unstable chest pain pattern: new & severe
	5	Unstable chest pain pattern: accelerated & severe
	8	No chest pain/discomfort
	9	Not stated/inadequately described

Guide for use: For Acute coronary syndrome (ACS) reporting, identifies the chest pain pattern described on presentation.

Code 1 Atypical chest pain. Pain, pressure, or discomfort in the chest, neck, or arms not clearly exertional or not otherwise consistent with pain or discomfort of myocardial ischaemic origin.

Code 2 Chest pain without a change in frequency or pattern for the 6 weeks before this presentation or procedure. Chest pain is controlled by rest and/or sublingual/oral/transcutaneous medications.

Code 3 Unstable chest pain pattern: rest &/or prolonged. Chest pain that occurred at rest and was prolonged, usually lasting more than 10 minutes.

Code 4 Unstable chest pain pattern: new & severe. New-onset chest pain that could be described as at least Canadian Cardiovascular Society (CCS) classification III severity.

Code 5 Unstable chest pain pattern: accelerated & severe. Recent acceleration of chest pain pattern that could be described by an increase in severity of at least 1 CCS class to at least CCS class III

Code 8 No chest pain/discomfort.

Code 9 Not stated/ inadequately described.

Chest pain or discomfort of myocardial ischaemic origin is usually described as chest pain, discomfort or pressure, jaw pain, arm pain or other equivalent discomfort suggestive of cardiac ischaemia. Ask the person when the symptoms first occurred or obtain this information from appropriate documentation.

Verification rules:

Collection methods:

Related metadata: Is used in conjunction with Time patient presents, version 2.

                             Is used in conjunction with Date patient presents, version 2.

                             Is a qualifier of Acute coronary syndrome stratum, version 1.

Information model link: NHIM   Physical wellbeing

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

Administrative attributes

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

Source organisation: Acute Coronary Syndrome Data Working Group.

Source document:

Registration authority: National Health Information Group.

Steward: The National Heart Foundation of Australia.

                             The Cardiac Society of Australia and New Zealand.

Comments: The Canadian Cardiovascular Society classes of angina can be used to support categorisation of chest pain patterns. Canadian Cardiovascular Society (CCS) classes of angina (Campeau L. *Grading of angina pectoris*. Circulation 1976; 54:522.)

                             1. Ordinary physical activity (for example, walking or climbing stairs) does not cause angina; angina occurs with strenuous or rapid or prolonged exertion at work or recreation

                             2. Slight limitation of ordinary activity (for example, angina occurs walking or stair climbing after meals, in cold, in wind, under emotional stress, or only during the few hours after awakening; walking more than 2 blocks on the level or climbing more than 1 flight of ordinary stairs at a normal pace; and in normal conditions)

                             3. Marked limitation of ordinary activity (for example, angina occurs with walking 1 or 2 blocks on the level or climbing 1 flight of stairs in normal conditions and at a normal pace)

                             4. Inability to perform any physical activity without discomfort; angina syndrome may be present at rest.

Clinical evidence status

Identifying and definitional attributes

Knowledgebase ID: **001026**   *Version number:*   **1**

Metadata type: Data element

Definition:	Indicator of the status of evidence for a pre-existing clinical condition.
Context:	Acute coronary treatment settings.

Relational and representational attributes

Data type: Numeric   *Maximum field size:*   1

Representational class: Code   *Format:*   N

Data domain:	1	objective evidence
	2	no objective evidence

Guide for use: **Acute coronary syndrome — DSS specific**

This data element seeks to ensure that patients with self-reported past symptoms pertinent to acute coronary syndrome, have objective evidence supporting reported diagnoses, using current medical practice.

For chronic lung disease

Objective evidence is coded where the diagnosis is supported by current use of chronic lung disease pharmacological therapy, or a forced expiratory volume in 1 second (FEV1) less than 80% predicted FEV1/FVC less than 0.7 (post bronchodilator). Respiratory failure PaO2 less than 60 mmHg (8kPa), or PaCO2 greater than 50 mmHg (6.7 kPa).

For heart failure

Objective evidence is coded where a patient has current symptoms of heart failure (typically breathlessness or fatigue), either at rest or during exercise and/or signs of pulmonary or peripheral congestion and objective evidence of cardiac dysfunction at rest. The diagnosis is derived from and substantiated by clinical documentation from testing according to current practices.

For stroke

For ischaemic: non-haemorrhagic cerebral infarction, objective evidence is coded where the diagnosis is supported by cerebral imaging (CT or MRI), or
For haemorrhagic: intracerebral haemorrhage, objective evidence is coded where the diagnosis is supported by cerebral imaging (CT or MRI).

For peripheral arterial disease

For Peripheral artery disease, objective evidence is coded where the diagnosis is derived from and substantiated by clinical documentation for a patient with a history of either chronic or acute occlusion or narrowing of the arterial lumen in the aorta or extremities.

For aortic aneurysm, objective evidence is coded when the diagnosis of aneurysmal dilatation of the aorta (thoracic and or abdominal) is supported and substantiated by appropriate documentation of objective testing.

For renal artery stenosis, objective evidence is coded when the diagnosis of functional stenosis of one or both renal arteries is present and is supported and substantiated by appropriate documentation of objective testing.

Sleep apnoea syndrome

Objective evidence is coded where the diagnosis is derived from and substantiated by clinical documentation of sleep apnoea syndrome (SAS). SAS has been diagnosed from the results of a sleep study.

Verification rules:

Collection methods: For each concurrent clinical condition — on presentation, the data element Clinical evidence status must also be recorded.

Related metadata: Is used in conjunction with the data element Concurrent clinical condition — on presentation, version 1.

Information model link: NHIM   Acute event

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

Administrative attributes

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

Source organisation: Acute Coronary Syndrome Data Working Group.

Source document:

Registration authority: National Health Information Group.

Steward:

Comments: **Chronic lung disease**

– current use of chronic lung disease pharmacological therapy (e.g. inhalers, theophylline, aminophylline, or steroids) and/or

– Note: the diagnosis rests on the airflow limitation which is not fully reversible. Consider treating as asthma if airflow limitation is substantially reversible. (The Thoracic Society of Australia & New Zealand and the Australian Lung Foundation, *Chronic Obstructive Pulmonary Disease (COPD) Australian & New Zealand Management Guidelines and the COPD Handbook.* Version 1, November 2002.)

Heart failure

The most widely available investigation for documenting left ventricular dysfunction is the transthoracic echocardiogram (TTE).

Other modalities include:

– transoesophageal echocardiography (TOE)

– radionuclide ventriculography (RVG)

- left ventriculogram (LVgram)

- magnetic resonance imaging (MRI).

In the absence of any adjunctive laboratory tests, evidence of supportive clinical signs of ventricular dysfunction. These include:

- third heart sound (S3)

- cardiomegaly

- elevated jugular venous pressure (JVP)

- chest X-ray evidence of pulmonary congestion.

Clinical procedure timing status

Identifying and definitional attributes

Knowledgebase ID:	**001027**	*Version number:*	**1**
Metadata type:	Data element		

Definition:	An indicator of the timing of the provision of a clinical procedure.
Context:	Acute coronary treatment settings.

Relational and representational attributes

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

Data domain:	1	procedure performed prior to an episode of admitted patient care
	2	procedure performed during an episode of admitted patient care

Guide for use:	Record only for those procedure codes that apply.
Verification rules:	
Collection methods:	This data element should be recorded for each type of procedure performed that is pertinent to the treatment of acute coronary syndrome.
Related metadata:	Is used in conjunction with Acute coronary syndrome procedure type, version 1.
	Is used in conjunction with Acute coronary syndrome stratum, version 1.
Information model link:	NHIM　　　Acute event

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

Administrative attributes

Admin. status:	CURRENT	*Effective Date:*	04/06/2004
Source organisation:	Acute Coronary Syndrome Data Working Group.		
Source document:			
Registration authority:	National Health Information Group.		
Steward:			
Comments:			

Clopidogrel therapy status

Identifying and definitional attributes

Knowledgebase ID:	**001028**	*Version number:*	**1**
Metadata type:	Data element		

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

Relational and representational attributes

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

Data domain:	10	Given
	21	Not given — therapy not indicated
	22	Not given — patient refusal
	23	Not given — true allergy to clopidogrel
	24	Not given — active bleeding
	25	Not given — bleeding risk
	26	Not given — thrombocytopenia
	27	Not given — severe hepatic dysfunction
	29	Not given — other
	90	Not stated/inadequately described

Guide for use:	If recording 'Not given', record the principal reason if more than one code applies.
Collection methods:	For Acute coronary syndrome (ACS) reporting, can be collected at any time point during the management of the current event (i.e. at the time of triage, at times during the admission, or at the time of discharge).
Related metadata:	
Information model:	NHIM　　　Physical wellbeing

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

Administrative attributes

Admin. status:	CURRENT	*Effective Date:*	04/06/2004
Source organisation:	Acute Coronary Syndrome Data Working Group.		
Source document:			
Registration authority:	National Health Information Group.		

Steward: The National Heart Foundation of Australia.

                            The Cardiac Society of Australia and New Zealand.

Comments:

Concurrent clinical condition — on presentation

Identifying and definitional attributes

Knowledgebase ID: **001029**   *Version number:*   **1**

Metadata type: Data element

Definition:	The concurrent medical conditions, which are pertinent to the risk stratification and treatment of acute coronary syndrome that a person has or has undergone prior to presentation.
Context:	Acute coronary syndrome clinical reporting only.

Relational and representational attributes

Data type: Numeric   *Maximum field size:*   2

Representational class: Code   *Format:*   NN

Data domain:	**Angina**
	   11 Angina for more than last two weeks
	   12 Angina only in the last two weeks
	
	Chronic lung disease
	   21 Chronic lung disease
	
	Heart failure
	   31 Heart failure
	
	Hypertension
	   41 Hypertension
	
	Stroke
	   51 Ischaemic: non-haemorrhagic cerebral infarction
	   52 Haemorrhagic: intracerebral haemorrhage
	
	Peripheral arterial disease
	   61 Peripheral artery disease
	   62 Aortic aneurysm
	   63 Renal artery stenosis
	
	Sleep Apnoea syndrome
	   71 Sleep apnoea
	
	   99 not stated/inadequately described

Guide for use:	More than one medical condition may be recorded. Record only those codes that apply. Record all codes that apply. Codes 21, 31, 51, 52, 61, 62, 63, and 71 must be accompanied by a Clinical evidence status code.

Acute coronary syndrome — DSS specific

Angina

Code 11 — This code is used where there are symptoms, which can be described as chest pain or pressure, jaw pain, arm pain, or other equivalent discomfort suggestive of cardiac ischaemia, for more than the last two weeks.

Code 12 — This code is used where there are symptoms, which can be described as chest pain or pressure, jaw pain, arm pain, or other equivalent discomfort suggestive of cardiac ischaemia, only in the last two weeks.

Chronic lung disease

Code 21 — This code is used where there is a history or symptoms suggestive of chronic lung disease.

Heart failure

Code 31 — This code is used where a patient has past or current symptoms of heart failure (typically breathlessness or fatigue), either at rest or during exercise and/or signs of pulmonary or peripheral congestion suggestive of cardiac dysfunction.

Hypertension

Code 41 — This code is used where there is current use of pharmacotherapy for hypertension and/or clinical evidence of high blood pressure.

Stroke

Code 51 — This code is used if there is history of stroke or cerebrovascular accident (CVA) resulting from an ischaemic event where the patient suffered a loss of neurological function with residual symptoms remaining for at least 24 hours.

Code 52 — This code is used if there is history of stroke or cerebrovascular accident (CVA) resulting from a haemorrhagic event where the patient suffered a loss of neurological function with residual symptoms remaining for at least 24 hours.

Peripheral arterial disease

Code 61 — This code is used where there is history of either chronic or acute occlusion or narrowing of the arterial lumen in the aorta or extremities.

Code 62 — This code is used where there is a history of aneurysmal dilatation of the aorta (thoracic and or abdominal).

Code 63 — This code is used where there is history of functional stenosis of one or both renal arteries.

Sleep apnoea syndrome

Code 71 — This code is used where there is evidence of sleep apnoea syndrome (SAS) on history.

Verification rules:

Collection methods:

Related metadata: Is qualified by the data element Clinical evidence status, version 1.

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

Information model link: NHIM   Health and wellbeing

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

Administrative attributes

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

Source organisation: Acute Coronary Syndrome Data Working Group.

Source document:

Registration authority: National Health Information Group.

Steward: The National Heart Foundation of Australia.

                             The Cardiac Society of Australia and New Zealand.

Comments:

Creatine kinase MB isoenzyme (CK-MB) — measured

Identifying and definitional attributes

Knowledgebase ID: ***001030***   *Version number:*   ***1***

Metadata type: Date element

Definition:	A person's measured creatine kinase MB isoenzyme (CK-MB).
Context:	Health care and clinical settings.

Relational and representational attributes

Data type: Numeric   *Maximum field size:*   5

Representational class: Code   *Format:*   NNNNN

Data domain:	Measured value,
	88888 Not measured
	99999 Not stated/inadequately described

Guide for use: Code 8888 if test for CK-MB was not done on this admission.

Measured in different units dependent upon laboratory methodology.

When only one CK-MB level is recorded, this should be the peak level during the admission.

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

Verification rules:

Collection methods:

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

Is qualified by Creatine kinase MB isoenzyme (CK-MB) − units, version 1

Is qualified by Creatine kinase MB isoenzyme (CK-MB) − upper limit of normal range, version 1

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

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

Information model link: NHIM   Service provision event

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

 DSS −   Acute coronary syndrome (clinical)   04/06/2004

Administrative attributes

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

Source organisation: Acute Coronary Syndrome Data Working Group.

Source document:

Registration authority: National Health Information Group.

Steward: The National Heart Foundation of Australia.

The Cardiac Society of Australia and New Zealand.

Comments:

Creatine kinase MB isoenzyme (CK-MB) — units

Identifying and definitional attributes

Knowledgebase ID: **001031**   *Version number:* **1**

Metadata type: Data element

Definition:	The units used to measure the CK-MB.
Context:	Health care and clinical settings.

Relational and representational attributes

Data type: Numeric   *Maximum field size:* 1

Representational class: Code   *Format:* N

Data domain:		
	1	µg/L (micrograms per litre) (immunoassay)
	2	IU
	3	%
	4	index
	5	ng/dl
	6	kCat/l
	9	Not stated/inadequately described

Guide for use:

Verification rules:

Collection methods:

Related metadata: Is a qualifier of Creatine kinase MB isoenzyme (CK-MB) — measured, version 1

Is a qualifier of Creatine kinase MB isoenzyme (CK-MB) — upper limit of normal range, version 1

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

Information model link: NHIM   Service provision event

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

Administrative attributes

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

Source organisation: Acute Coronary Syndrome Data Working Group.

Source document:

Registration authority: National Health Information Group.

Steward: The National Heart Foundation of Australia.

                                 The Cardiac Society of Australia and New Zealand.

Comments:

Registration authority: National Health Information Group.

Steward: The National Heart Foundation of Australia.

                                 The Cardiac Society of Australia and New Zealand.

Comments:

Creatine kinase MB isoenzyme (CK-MB) — upper limit of normal range

Identifying and definitional attributes

Knowledgebase ID:	***001032***	*Version number:*	***1***
Metadata type:	Data element		

Definition:	Laboratory standard for the value of creatine kinase MB isoenzyme (CK-MB) that is the upper boundary of the normal reference range.
Context:	Health care and clinical settings.

Relational and representational attributes

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

Data domain:	CK-MB value, or
	9999 Not stated/Inadequately described

Guide for use:	Record the upper limit of the CK-MB normal reference range for the testing laboratory.
Verification rules:	
Collection methods:	
Related metadata:	Is qualified by Creatine kinase MB isoenzyme (CK-MB) — units, version 1.
	Is a qualifier of Creatine kinase MB isoenzyme (CK-MB) — measured, version 1.
	Is used in conjunction with Date creatine kinase MB isoenzyme (CK-MB) measured, version 1.
Information model link:	NHIM Service provision event

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

Administrative attributes

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

Date creatine kinase MB isoenzyme (CK-MB) measured

Identifying and definitional attributes

Knowledgebase ID:	**001033**	*Version number:*	**1**
Metadata type:	Data element		

Definition:	The date a creatine kinase MB isoenzyme (CK-MB) is measured.
Context:	Health care and clinical settings.

Relational and representational attributes

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

Data domain:	Valid date.

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

Verification rules:

Collection methods:

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

is used in conjunction with Creatine kinase MB isoenzyme (CK-MB) — units, version 1

is used in conjunction with Creatine kinase MB isoenzyme (CK-MB) — upper limit of normal range, version 1

is used in conjunction with Time Creatine kinase Mb isoenzyme (CK-MB) measured, version 1

Information model link: NHIM   Service provision event

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

Administrative attributes

Admin. status:	CURRENT	*Effective Date:*	04/06/2004
Source organisation:	Acute Coronary Syndrome Data Working Group.		

Source document:

Registration authority: National Health Information Group.

Steward: The National Heart Foundation of Australia.

The Cardiac Society of Australia and New Zealand.

Comments:

Date of death

Identifying and definitional attributes

Knowledge base ID: **001063**   *Version number:*   **1**

Metadata type: Data element

Definition:	The date of death of the person.
Context:	Required for statistical survival analysis for derivation of the length of time between diagnosis with primary cancer and death.

Relational and representational attributes

Data type: Numeric   *Maximum field size:*   8

Representational class: Date   *Format:*   DDMMYYYY

Data domain:	Valid date.

Guide for use: Recorded for patients who have died.

Verification rules: This field must be greater than or equal to Date of diagnosis of primary cancer.

Collection methods: It is recommended that in cases where all components of the date of death are not known or where an estimate is arrived at from age, a valid date be used together with a flag to indicate that it is an estimate.

Related metadata:

Information model link: NHIM   Demographic characteristic

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

   DSS — Cancer (clinical)   04/06/2004

Administrative attributes

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

Source organisation: Health Data Standards Committee.

Source document:

Registration authority: National Health Information Group.

Steward:

Comments:

Date of diagnosis of first recurrence

Identifying and definitional attributes

Knowledgebase ID:	**001064**	*Version number:*	**1**
Metadata type:	Data element		

Definition:	The date a medical practitioner confirms the diagnosis of a recurrent or metastatic cancer of the same histology.
Context:	This item is collected for determining the time interval from diagnosis to recurrence, from treatment to recurrence and from recurrence to death.

Relational and representational attributes

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

Data domain:	Valid date.

Guide for use:	The term 'recurrence' defines the return, reappearance or metastasis of cancer (of the same histology) after a disease free period.
Verification rules:	This field must:

– 　be greater than Date of diagnosis of cancer

– 　be greater than Cancer initial treatment — completion date (if less than Cancer initial treatment — completion date, the patient was never disease-free)

Collection methods:	
Related metadata:	Relates to the data element Region of first recurrence, version 1.
Information model link:	NHIM　　　Request for/entry into service event

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

Administrative attributes

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

Date of first angioplasty balloon inflation or stenting

Identifying and definitional attributes

Knowledgebase ID:	**001034**	*Version number:*	**1**
Metadata type:	Data element		

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

Relational and representational attributes

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

Data domain:	Valid date.

Guide for use:	For Acute coronary syndrome (ACS) reporting, refers to the Date of first angioplasty balloon inflation or coronary stenting for this admission.
Verification rules:	For Acute coronary syndrome (ACS) reporting, must be the same as, or later than the Date of triage.
Collection methods:	
Related metadata:	Is used in conjunction with Acute coronary syndrome procedure type, version 1
	Is used in conjunction with Time of first angioplasty balloon inflation or stenting, version 1
	Is used in conjunction with Date of triage, version 1
	Is used in conjunction with Time of triage, version 1
Information model link:	NHIM Service provision event

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

Administrative attributes

Admin. status:	CURRENT	*Effective Date:*	04/06/2004
Source organisation:	Acute Coronary Syndrome Data Working Group.		
Source document:			
Registration authority:	National Health Information Group.		

Steward: The National Heart Foundation of Australia.

                                              The Cardiac Society of Australia and New Zealand.

Comments:

Date of intravenous fibrinolytic therapy

Identifying and definitional attributes

Knowledgebase ID: **001035**   *Version number:* **1**

Metadata type: Data element

Definition:	The date intravenous (IV) fibrinolytic therapy was administered or initiated.
Context:	Health care and clinical settings.

Relational and representational attributes

Data type: Numeric   *Maximum field size:* 8

Representational class: Date   *Format:* DDMMYYYY

Data domain:	Valid date.

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

Verification rules:

Collection methods:

Related metadata: Is used in conjunction with Acute coronary syndrome procedure type, version 1.

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

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

Is used in conjunction with Fibrinolytic drug used, version 1.

Is used in conjunction with Time of intravenous fibrinolytic therapy, version 1.

Information model link: NHIM   Service provision event

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

Administrative attributes

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

Source organisation: Acute Coronary Syndrome Data Working Group.

Source document:

Registration authority: National Health Information Group.

Steward: The National Heart Foundation of Australia.

                                  The Cardiac Society of Australia and New Zealand.

Comments:

Date of surgical treatment for cancer

Identifying and definitional attributes

Knowledgebase ID:	**001065**	*Version number:*	**1**
Metadata type:	Data element		

Definition:	The date on which the cancer-directed surgical treatment was performed.
Context:	This item is collected for analyses of outcome by treatment type.

Relational and representational attributes

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

Data domain:	Valid date.

Guide for use:	The date of each surgical treatment episode should be entered separately. Collected for curative and palliative surgery prior to the first recurrence.
Verification rules:	This field must be greater than or equal to Date of diagnosis of cancer.
Collection methods:	
Related metadata:	Relates to the data element concept Initial treatment episode for cancer, version 1.
	Relates to data element Surgical treatment procedure for cancer, version 1.
Information model link:	NHIM Service provision event

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

Administrative attributes

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

Date troponin measured

Identifying and definitional attributes

Knowledgebase ID: **001036**   *Version number:*   **1**

Metadata type: Data element

Definition:	Date the troponin assay is measured.
Context:	Health care and clinical settings.

Relational and representational attributes

Data type: Numeric   *Maximum field size:*   8

Representational class: Date   *Format:*   DDMMYYYY

Data domain:	Valid date.

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

Verification rules:

Collection methods:

Related metadata: Is used in conjunction with Time troponin measured, version 1.

Is used in conjunction with Troponin measured, version 1.

Is used in conjunction with Troponin assay type, version 1.

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

Information model link: NHIM   Service provision event

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

Administrative attributes

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

Source organisation: Acute Coronary Syndrome Data Working Group.

Source document:

Registration authority: National Health Information Group.

Steward: The National Heart Foundation of Australia.

The Cardiac Society of Australia and New Zealand.

Comments:

Degree of spread of cancer

Identifying and definitional attributes

Knowledgebase ID:	*000862*	*Version number:*	*1*
Metadata type:	Data element		

Definition:	Degree of spread of cancer is a measure of the progression/extent of cancer at a particular point in time.
Context:	This information is collected for the purpose of:

 – determining what proportion of cancers are localised to the site of the primary cancer at the time of diagnosis.

 – indicating the extent of disease at the time of diagnosis.

 – for previously diagnosed cancers, the degree of spread may be measured at each patient episode to track the progression of the cancer.

 – assessing how early in its course the cancer was diagnosed (used to assess impact of early diagnosis measure).

 Estimating severity by degree of spread (used for comparing survival after adjusting for degree of spread).

Relational and representational attributes

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

Data domain:	Degree of spread of cancer:
	1 Localised to the tissue of origin
	2 Invasion of adjacent tissue or organs
	3 Regional lymph nodes
	4 Distant metastases
	5 Not applicable
	9 Unknown

Guide for use:	The valid values for the variable are listed below.

Code 1   Localised to the tissue of origin: Includes a primary cancer where the spread is contained within the organ of origin.

Note: this includes in situ breast (D05.0–D05.9) and in situ melanoma (D03.0–D03.9)

Example 1: For colon cancer, the cancer has not progressed into the adventitia (peritoneal layer) surrounding the colon.

Example 2: For breast cancer, the cancer has not progressed into the underlying muscle layer (pectoral) or externally to the skin.

Example 3: For melanoma of the skin, the cancer has not invaded the subcutaneous fat layer (that is, it is contained within the dermis and epidermis).

Example 4: For lung cancer, the cancer has not invaded the pleura.

Code 2   Invasion of adjacent tissue or organs: A primary cancer has spread to adjacent organs or tissue not forming part of the organ of origin. This category includes sub-cutaneous fat or muscle and organs adjacent to the primary cancer site.

Example 1: For colon cancer, the cancer has progressed into the adventitia (peritoneal layer) surrounding the colon.

Example 2: For breast cancer, the degree of spread has progressed into the underlying muscle layer (pectoral) or externally into the skin.

Example 3: For melanoma of the skin, the cancer has invaded into subcutaneous fat or muscle.

Example 4: For lung cancer, the cancer has invaded the pleura or tissues of the mediastinum.

Code 3   Regional lymph nodes: The primary cancer has metastasised to the nearby draining lymph nodes.

The list below shows the regional lymph nodes by site of primary cancer (International Union Against Cancer's definition).

Head and neck — Cervical nodes

Larynx — Cervical nodes

Thyroid — Cervical and upper mediastinal nodes

Stomach — Perigastric nodes along the lesser and greater curvatures

Colon and rectum — Pericolic, perirectal, and those located along the ileocolic, right colic, middle colic, left colic, inferior mesenteric and superior rectal

Anal — Perirectal, internal iliac, and inguinal lymph nodes

Liver — Hilar nodes, e.g. the hepatoduodenal ligament

Pancreas — Peripancreatic nodes

Lung — Intrathoracic, scalene and supraclavicular

Breast — Axillary, interpectoral, internal mammary

Cervix — Paracervical, parametrial, hypogastric, common, internal and external iliac, presacral and sacral

Ovary — Hypogastric (obturator), common iliac, external iliac, lateral, sacral, paraortic and inguinal

Prostate and bladder — Pelvic nodes below the bifurcation of the common iliac arteries

Testes — Abdominal, para-aortic and paracaval nodes, the intrapelvic and inguinal nodes

Kidney — Hilar, abdominal, para–aortic or paracaval

Code 4   Distant metastases: The primary cancer has spread to sites distant to the primary site, for example liver and lung and bone, or any lymph nodes not stated as regional to the site (see '3 – Regional lymph nodes' above).

Code 5   Not Applicable: This category applies for lymphatic and haematopoietic cancers, e.g. myelomas, leukaemias and lymphomas (C81.0–C96.9) only.

Code 9   Unknown: No information is available on the degree of spread at this episode or the available information is insufficient to allow classification into one of the preceding categories

Verification rules:

Collection methods:

Related metadata:

Information model link: NHIM   Assessment event

Administrative attributes

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

Source organisation: World Health Organization.
NSW Health Department.

Source document: *Full International Classification of Diseases for Oncology*, Second Edition (ICD-O-2).

NSW Inpatient Statistics Collection Manual–2000/2001.

Registration authority: National Health Information Group.

Steward:

Comments:

Electrocardiogram (ECG) change — location

Identifying and definitional attributes

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

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

Relational and representational attributes

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

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

Guide for use:	Code 4 True posterior is relevant only for tall R waves.
	More than one code may be recorded.
	Report in order of significance.
	Record all codes that apply (codes 8 and 9 are excluded from multiple coding).
Verification rules:	
Collection methods:	
Related metadata:	Used in conjunction with the data element Electrocardiogram (ECG) change — type, version 1.
Information model link:	NHIM Service provision event

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

Administrative attributes

Admin. status:	CURRENT	*Effective Date:*	04/06/2004
Source organisation:	Acute Coronary Syndrome Data Working Group.		
Source document:			

Registration authority: National Health Information Group.

Steward: The National Heart Foundation of Australia.

The Cardiac Society of Australia and New Zealand.

Comments:

Electrocardiogram (ECG) change—type

Identifying and definitional attributes

Knowledgebase ID: **001038**   *Version number:*   **1**

Metadata type: Data element

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

Relational and representational attributes

Data type: Numeric   *Maximum field size:*   1

Representational class: Code   *Format:*   N

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

Guide for use:	For Acute coronary syndrome (ACS) reporting, used to determine diagnostic strata.
	More than one code may be recorded.
	Record all that apply (codes 7, 8 and 9 are excluded from multiple coding).
	Code 1 ST-segment elevation indicates greater than or equal to 1 mm (0.1 mV) elevation in 2 or more contiguous limb leads
	Code 2 ST-segment elevation indicates greater than or equal to 2 mm (0.2 mV) elevation in 2 or more contiguous chest leads
	Code 3 ST-segment depression of at least 0.5 mm (0.05 mV) in 2 or more contiguous leads (includes reciprocal changes)
	Code 4 T-wave inversion of at least 1 mm (0.1 mV) including inverted T waves that are not indicative of acute MI
	Code 5 Q waves refer to the presence of Q waves that are greater than or equal to 0.03 seconds in width and greater than or equal to 1 mm (0.1 mV) in depth in at least 2 contiguous leads
	Code 6 Bundle branch block pattern
	Code 7 Changes not meeting the above criteria
	Code 8 No ECG changes
	Code 9 includes unknown

Verification rules:

Collection methods:

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

Is used in conjunction with the data element Acute coronary syndrome procedure type, version 1.

Is used in conjunction with Electrocardiogram (ECG) change — location, version 1.

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

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

Information model link: NHIM   Service provision event

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

Administrative attributes

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

Source organisation: Acute Coronary Syndrome Data Working Group.

Source document:

Registration authority: National Health Information Group.

Steward: The National Heart Foundation of Australia.

The Cardiac Society of Australia and New Zealand.

Comments:

Episode of residential care

Identifying and definitional attributes

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

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

Relational and representational attributes

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

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related metadata:	Relates to the data element concept Episode of residential care end, version 1.
	Relates to the data element concept Episode of residential care start, version 1.
	Relates to the data element concept Resident, version 1.
	Relates to data element Episode of residential care end date, version 1.
	Relates to data element Episode of residential care start date, version 1.
	Relates to data element Residential stay start date, version 1.
Information model link:	NHIM Service provision event

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

Administrative attributes

Admin. status:	CURRENT	*Effective Date:* 14/11/2003
Source organisation:		
Source document:		
Registration authority:	National Health Information Group.	

Steward:

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

Episode of residential care end

Identifying and definitional attributes

Knowledgebase ID:	**000893**	*Version number:*	**1**
Metadata type:	Data element concept		

Definition:	Episode of residential care end is the administrative process by which a residential care service either records:
	Formal episode of residential care end
	– The formal end of residential care and accommodation of a resident,
	– The end of residential care and accommodation of a resident who has commenced leave where there is no intention that the resident returns to residential care within seven days, or
	Statistical episode of residential care end
	– The end of the reference period.
Context:	Specialised mental health services (Residential mental health care).

Relational and representational attributes

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

Data domain:	

Guide for use:	
Verification rules:	
Collection methods:	
Related metadata:	Relates to the data element concept Episode of residential care start, version 1.
	Relates to the data element concept Resident, version 1.
	Relates to the data element Episode of residential care end date, version 1.
Information model link:	NHIM Exit/leave from service event

Administrative attributes

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

Registration authority: National Health Information Group.

Steward:

Comments:

Episode of residential care end date

Identifying and definitional attributes

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

Definition:	Date on which a resident formally or statistically ends an episode of residential care.
Context:	Specialised mental health services (Residential mental health care).

Relational and representational attributes

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

Data domain:	Valid date.

Guide for use:

Verification rules:	Data in this field must be:

— less than or equal to last day of reference period

— greater than or equal to first day of reference period

— greater than or equal to Episode of residential care start date

Collection methods:

Related metadata:	Relates to the data element concept Episode of residential care end, version 1.
	Relates to the data element concept Episode of residential care, version 1.
	Relates to the data element concept Resident, version 1.
Information model link:	NHIM Exit/leave from service event

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

Administrative attributes

Admin. status:	CURRENT	*Effective Date:*	14/11/2003
Source organisation:			
Source document:			
Registration authority:	National Health Information Group.		
Steward:			
Comments:			

Episode of residential care end mode

Identifying and definitional attributes

Knowledgebase ID: ***000895***   *Version number:*   ***1***

Metadata type: Data element

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

Relational and representational attributes

Data type: Numeric   *Maximum field size:*   1

Representational class: Code   *Format:*   N

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

Guide for use:

Verification rules:

Collection methods:

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

Information model link: NHIM   Exit/leave from service event

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

Administrative attributes

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

Source organisation:

Source document:

Registration authority: National Health Information Group.

Steward:

Comments:

Episode of residential care start

Identifying and definitional attributes

Knowledgebase ID: **000896**   *Version number:*   **1**

Metadata type: Data element concept

Definition:	Episode of residential care start is the process whereby the residential care service accepts responsibility for the Resident's residential care and accommodation. Episode of residential care start is the administrative process by which a residential care service records either:
	Formal episode of residential care start
	– The start of residential care and accommodation of a resident, and,
	– The unplanned return from leave of a resident (when there had been no intention of returning to overnight residential care within seven days), or
	Statistical episode of residential care start
	– The start of a reference period for a resident continuing their residential care and accommodation, from the previous reference period.
Context:	

Relational and representational attributes

Data type: *Maximum field size:*

Representational class: *Format:*

Data domain:	

Guide for use:

Verification rules:

Collection methods:

Related metadata:	Relates to the data element concept Episode of residential care end, version 1.
	Relates to the data element concept Resident, version 1.
	Relates to the data element Episode of residential care start date, version 1.
Information model link:	NHIM Request for/entry into service event

Administrative attributes

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

Source organisation:

Source document:

Registration authority: National Health Information Group.

Steward:

Comments:

Episode of residential care start date

Identifying and definitional attributes

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

Definition:	Date on which the resident starts an episode of residential care either because of:
	Formal episode of residential care start
	– The start of treatment and/or care and accommodation of a resident, or
	Statistical episode of residential care start
	– The start of a reference period for a resident continuing their treatment and/or care and accommodation from the previous reference period.
Context:	Specialised mental health services (Residential mental health care).

Relational and representational attributes

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

Data domain:	Valid date.

Guide for use:	
Verification rules:	Right justified and zero filled.
	Episode of residential care start date must be less than or equal to episode of residential care end date.
	Episode of residential care start date must be greater than or equal to date of birth.
Collection methods:	
Related metadata:	Relates to the data element concept Episode of residential care start, version 1.
	Relates to the data element concept Resident, version 1.
	Relates to the data element concept Episode of residential care, version 1.
Information model link:	NHIM Request for/entry into service event

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

Administrative attributes

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

Source organisation:

Source document:

Registration authority: National Health Information Group.

Steward:

Comments:

Episode of residential care start mode

Identifying and definitional attributes

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

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

Relational and representational attributes

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

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

Guide for use:

Verification rules:

Collection methods:

Related metadata:	Is supplemented by the data element Source of mental health service transfer to residential care, version 1.
Information model link:	NHIM Exit/leave from service event

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

Administrative attributes

Admin. status:	CURRENT	*Effective Date:*	14/11/2003
Source organisation:			
Source document:			
Registration authority:	National Health Information Group.		
Steward:			
Comments:			

Fibrinolytic drug used

Identifying and definitional attributes

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

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

Relational and representational attributes

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

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

Guide for use:	For Acute coronary syndrome (ACS) reporting, this data element pertains to the administering of fibrinolytic therapy drugs at any time point during this current event.
Verification rules:	
Collection methods:	
Related metadata:	Is used in conjunction with Date of intravenous fibrinolytic therapy, version 1.
	Is used in conjunction with Time of intravenous fibrinolytic therapy, version 1.
Information model link:	NHIM Physical wellbeing

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

Administrative attributes

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

Fibrinolytic therapy status

Identifying and definitional attributes

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

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

Relational and representational attributes

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

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

Guide for use:	More than one code may be recorded for the following codes: 23, 24, 25, 26, 27, 28, 29, 30 and 31.
	For Acute coronary syndrome (ACS) reporting, to be collected with the data elements Date of triage, Time of triage and Acute coronary syndrome stratum. This data element pertains to the administering of fibrinolytic therapy drugs at any time point during this current event.

Verification rules:

Collection methods:

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

| *Information model:* | NHIM | Physical wellbeing |

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

Administrative attributes

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

Floor/level number

Identifying and definitional attributes

Knowledge base ID: **001010**   *Version number:*   **1**

Metadata type: Data element

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

Relational and representational attributes

Data type: Alphanumeric   *Maximum field size:*   4

Representational class: Text   *Format:*   AN(4)

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

Guide for use:	The Floor/level number must be recorded with its corresponding Floor/level type.
	Some Floor/level numbers may be followed by an alphabetic suffix.
	Examples of Floor/level identification:
	FL 1A
	L 3
	LG A
Verification rules:	
Collection methods:	Do not leave a space between the number and alpha suffix.
	To be collected in conjunction with Floor/level type.
Related metadata:	Relates to the data element Floor/level type, version 1.
	Is a composite part of the data element Address line, version 1.
Information model link:	NHIM Address element

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

Administrative attributes

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

Source organisation: Health Data Standards Committee.

Source document: Australia Post Address Presentation Standard.

Registration authority: National Health Information Group.

Steward: Health Data Standards Committee.

Comments:

Floor/level type

Identifying and definitional attributes

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

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

Relational and representational attributes

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

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

Guide for use:	Some floor/level identification may require the Floor/level type plus a Floor/level number to be recorded.
Verification rules:	
Collection methods:	To be collected in conjunction with Floor/level number where applicable. Some Floor/level type entries will often have no corresponding number, e.g. Basement, Ground, Lower ground, Mezzanine and Upper ground.
Related metadata:	Relates to the data element Floor/level number, version 1.
	Is a composite part of the data element Address line, version 1.
Information model link:	NHIM Address element

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

Administrative attributes

Admin. status:	CURRENT	*Effective Date:*	25/02/2004
Source organisation:	Health Data Standards Committee.		
Source document:	Australia Post Address Presentation Standard.		

Registration authority: National Health Information Group.

Steward: Health Data Standards Committee.

Comments:

Functional stress test element

Identifying and definitional attributes

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

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

Relational and representational attributes

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

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

Guide for use:	More than one code may be recorded (code 9 is excluded from multiple coding).
Verification rules:	
Collection methods:	
Related metadata:	is a qualifier of Functional stress test ischaemic result, version 1
Information model:	NHIM Service provision event

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

Administrative attributes

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

Functional stress test ischaemic result

Identifying and definitional attributes

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

Definition:	Indicates the result of the person's electrocardiogram stress in terms of ischaemic outcome.
Context:	Health care and clinical settings.

Relational and representational attributes

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

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

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

Code 2. Positive:

> On an exercise tolerance test, the patient developed either:
>
> > a. Both ischaemic discomfort and ST shift greater than or equal to 1 mm (0.1 mV) (horizontal or downsloping) or
> >
> > b. New ST shift greater than or equal to 2 mm (0.2 mV) (horizontal or down-sloping) believed to represent ischaemia even in the absence of ischaemic discomfort.
>
> On cardiac imaging investigation (e.g. exercise thallium or MIBI test, stress echocardiography, or dipyridamole, thallium, or adenosine radioisotope scan)
>
> > a. Evidence of reversible ischaemia on nuclear imaging of the myocardium
> >
> > b. Evidence of inducible ischaemic response during echocardiographic imaging of the myocardium

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

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

Code 4. Equivocal: Either

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

Verification rules:

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

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

                               is qualified by Functional stress test elements, version 1

                               is used in conjunction with the data element Clinical procedure timing status, version 1

Information model: NHIM   Physical wellbeing

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

Administrative attributes

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

Source organisation: Acute Coronary Syndrome Data Working Group.

Source document:

Registration authority: National Health Information Group.

Steward: The National Heart Foundation of Australia.

                               The Cardiac Society of Australia and New Zealand.

Comments:

Glycoprotein IIb/IIIa receptor antagonist status

Identifying and definitional attributes

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

Definition:	Identifies the person's glycoprotein IIb/IIIa receptor antagonist therapy status.
Context:	Health care and clinical settings.

Relational and representational attributes

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

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

Guide for use:	If recording 'Not given', record the principal reason if more than one code applies.
	This data element pertains to the administering of Glycoprotein IIb/IIIa receptor antagonist drugs at any time point during this current event.

Verification rules:

Collection methods:

Related metadata:

Information model:	NHIM	Physical wellbeing

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

Administrative attributes

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

Registration authority: National Health Information Group.

Steward: The National Heart Foundation of Australia.

The Cardiac Society of Australia and New Zealand.

Source organisation: Acute Coronary Syndrome Data Working Group.

Source document:

Comments:

Heart rate

Identifying and definitional attributes

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

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

Relational and representational attributes

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

Data domain:	997	Cardiac arrest
	998	Not recorded
	999	Not stated/inadequately described

Guide for use:	Measurement expressed in beats per minute.
Verification rules:	
Collection methods:	For Acute coronary syndrome (ACS) reporting, collected at time of presentation. If heart rate is not recorded at the exact time of presentation, record the first heart rate measured closest to the time of presentation.
Related metadata:	is used in conjunction with Time patient presents, version 2
	is used in conjunction with Heart rhythm type, version 1
Information model:	NHIM Service provision event

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

Administrative attributes

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

Heart rhythm type

Identifying and definitional attributes

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

Definition:	The type of rhythm associated with the beating of the heart as determined from the electrocardiogram (ECG).
Context:	Health care and clinical settings.

Relational and representational attributes

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

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

Guide for use:	For Acute coronary syndrome (ACS) reporting, the ECG used for assessment on presentation.
Collection methods:	
Related metadata:	Is a qualifier of Reason for readmission – acute coronary syndrome, version 1
	Is used in conjunction with Date of triage, version 1
	Is used in conjunction with Time of triage, version 1
	Is used in conjunction with Heart rate, version 1
	Is used in conjunction with the data element Acute coronary syndrome procedure type, version 1
	Is used in conjunction with the data element Electrocardiogram (ECG) change — type, version 1
Information model:	NHIM Physical wellbeing

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

Administrative attributes

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

Source organisation: Acute Coronary Syndrome Data Working Group.

Source document:

Registration authority: National Health Information Group.

Steward: The National Heart Foundation of Australia.

The Cardiac Society of Australia and New Zealand.

Comments:

Histopathological grade

Identifying and definitional attributes

Knowledgebase ID: **001066**   *Version number:*   **1**

Metadata type: Data element

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

Relational and representational attributes

Data type: Numeric   *Maximum field size:*   1

Representational class: Code   *Format:*   N

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

	1	Grade 1:	Well differentiated, differentiated, NOS
	2	Grade 2:	Moderately differentiated, moderately well differentiated, intermediate differentiation
	3	Grade 3:	Poorly differentiated
	4	Grade 4:	Undifferentiated, anaplastic

Lymphomas and leukaemias

	5	T-cell:	T-cell
	6	B-cell:	B-cell, Pre-B, B-Precursor
	8	NK:	Natural killer cell

Unknown or not stated

	9	Grade/differentiation unknown: Grade/cell type not determined, not stated or not applicable

Guide for use: Only one code can be recorded.

Verification rules:

Collection methods:

Related metadata: Relates to the data element Morphology of cancer, version 1.

Relates to the data element Date of diagnosis of cancer, version 1.

Relates to the data element Primary site of cancer, version 1.

Information model link: NHIM   Assessment event

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

Administrative attributes

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

Source organisation:	World Health Organization.
	Commission on Cancer, American College of Surgeons.
Source document:	World Health Organization, *International Classification of Diseases Oncology*, Third edition (ICD-O-3) *(2000).*
	Commission on Cancer, *Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS)* Volume II (1998).
Registration authority:	National Health Information Group.
Steward:	
Comments:	

House/property number

Identifying and definitional attributes

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

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

Relational and representational attributes

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

Data domain:	Valid alphanumeric characters.

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

- House/property number 1 — refers to physical House/property number and for ranges is the starting number (five numeric characters)

- House/property number Suffix 1 — a single character identifying the House/property number suffix (one alphanumeric character)

- House/property number 2 — refers to a physical House/property number and for ranges is the finishing number (five numeric characters)

- House/property number suffix 2 — a single character identifying the House/property number suffix (one alphanumeric character) with no space between the numeric and the alpha characters.

For example; '401A 403B'

'401' is House/property number first in range

'A' is the House/Property suffix 1

'403' is House/property number last in range

'B' is House/Property suffix 2

Verification rules:	
Collection methods:	
Related metadata:	Is a composite part of the data element Address line, version 1.
Information model link:	NHIM Address element

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

Administrative attributes

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

Source organisation: Health Data Standards Committee.

Source document: Australia Post Address Presentation Standard.

Registration authority: National Health Information Group.

Steward: Health Data Standards Committee.

Comments:

Initial treatment episode for cancer

Identifying and definitional attributes

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

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

Relational and representational attributes

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

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related metadata:	Relates to the data element Intention of treatment for cancer, version 1.
	Relates to the data element Cancer treatment — target site, version 1.
	Relates to the data element Cancer treatment type, version 1.
	Relates to the data element Surgical treatment procedure for cancer, version 1.
	Relates to the data element Radiotherapy treatment given, version 1.
	Relates to the data element Received radiation dose, version 1.
	Relates to the data element Systemic therapy agent name, version 1.
	Relates to the data element Date of surgical treatment for cancer, version 1.
	Relates to the data element Cancer initial treatment — starting date, version 1.
	Relates to the data element Cancer initial treatment — completion date, version 1.
Information model link:	NHIM Request for/entry into service event

Administrative attributes

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

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

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

Commission on Cancer, *Facility Oncology Registry Data Standards* (2002).

Registration authority: National Health Information Group.

Steward:

Comments:

Intention of treatment for cancer

Identifying and definitional attributes

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

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

Relational and representational attributes

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

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

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

Verification rules:

Collection methods:

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

Information model link:	NHIM	Exit/leave from service event

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

Administrative attributes

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

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

New South Wales Health Department.

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

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

Registration authority: National Health Information Group.

Steward:

Comments:

Killip classification code

Identifying and definitional attributes

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

Definition:	Identifies the Killip class, as a measure of haemodynamic compromise, of the person at the time of presentation.
Context:	Health care and clinical settings.

Relational and representational attributes

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

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

Guide for use:	Code 1	Absence of crepitations/rales over the lung fields and absence of S3.
	Code 2	Crepitations/rales over 50% or less of the lung fields or the presence of an S3.
	Code 3	Crepitations/rales over more than 50% of the lung fields.
	Code 4	Cardiogenic Shock. Clinical criteria for cardiogenic shock are hypotension (a systolic blood pressure of less than 90 mmHg for at least 30 minutes or the need for supportive measures to maintain a systolic blood pressure of greater than or equal to 90 mmHg), end-organ hypoperfusion (cool extremities or a urine output of less than 30 ml/h, and a heart rate of greater than or equal to 60 beats per minute). The haemodynamic criteria are a cardiac index of no more than 2.2 l/min per square meter of body-surface area and a pulmonary-capillary wedge pressure of at least 15 mmHg.

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

Verification rules:	
Collection methods:	For Acute coronary syndrome (ACS) reporting, Killip classification at the time of presentation.
Related metadata:	Is a qualifier of Acute coronary syndrome stratum, version 1
Information model:	NHIM Physical wellbeing

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

Administrative attributes

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

Source organisation: Acute Coronary Syndrome Data Working Group.

Source document:

Registration authority: National Health Information Group.

Steward: The National Heart Foundation of Australia.

The Cardiac Society of Australia and New Zealand.

Comments:

Leave days from residential care

Identifying and definitional attributes

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

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

Relational and representational attributes

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

Data domain:	Count in number of days.

Guide for use:	A day is measured from midnight to midnight.
	Leave days can occur for a variety of reasons, including:
	– treatment by specialised mental health service
	– treatment by a non-specialised health service
	– time in the community
	The following rules apply in the calculation of leave days:
	– the day the resident goes on leave is counted as a leave day
	– days the resident is on leave is counted as leave days
	– the day the resident returns from leave is not counted as a leave day
	– if the resident starts a residential stay and goes on leave on the same day, this is not counted as a leave day
	– if the resident returns from leave and then goes on leave again on the same day, this is counted as a leave day
	– if the resident returns from leave and ends residential care on the same day, the day should not be counted as leave day
	– leave days at the end of a residential stay after the commencement of leave are not counted.
	If a period of leave is greater than seven days or the resident fails to return from leave, then the residential stay is formally ended.
Verification rules:	Episode of residential care end date minus episode of residential care start date minus leave days from residential care must be greater than or equal to zero days.
Collection methods:	
Related metadata:	Relates to the data element concept Episode of residential care end, version 1.
	Relates to the data element concept Episode of residential care start, version 1.

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

Relates to the data element concept Resident, version 1.

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

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

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

Information model link: NHIM   Exit/leave from service event

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

Administrative attributes

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

Source organisation:

Source document:

Registration authority: National Health Information Group.

Steward:

Comments:

Lipid-lowering therapy status

Identifying and definitional attributes

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

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

Relational and representational attributes

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

Data domain:	10	Given
	21	Not given—patient refusal
	22	Not given—true allergy to lipid lowering therapy
	23	Not given—previous myopathy
	24	Not given—hepatic dysfunction
	25	Not given—other
	90	Not stated/inadequately described

Guide for use:	If recording 'Not given', record the principal reason if more than one code applies.
Verification rules:	
Collection methods:	For Acute coronary syndrome (ACS) reporting, can be collected at any time point during the management of the current event (i.e. at the time of triage, at times during the admission, or at the time of discharge).
Related metadata:	
Information model:	NHIM Physical wellbeing

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

Administrative attributes

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

Lot/section number

Identifying and definitional attributes

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

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

Relational and representational attributes

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

Data domain:	Valid alphanumeric characters.

Guide for use:	This standard is suitable for postal purposes as well as the physical identification of addresses.
	A lot number shall be used only when a street number has not been specifically allocated or is not readily identifiable with the property.
	For identification purposes, the word 'Lot' or 'Section' should precede the lot number and be separated by a space.
	Examples are as follows:
	Section 123456
	Lot 716
	Lot 534A
	Lot 17 Jones Street
Verification rules:	
Collection methods:	The Lot/section number is positioned before the Street name and type, located in the same line containing the Street name.
Related metadata:	Is a composite part of the data element Address line, version 1.
Information model link:	NHIM Address element

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

Administrative attributes

Admin. status:	CURRENT	*Effective Date:*	25/02/2004
Source organisation:	Health Data Standards Committee.		
Source document:	AS4590 Interchange of client information.		
	Australia Post Address Presentation Standard.		

Registration authority:	National Health Information Group.
Steward:	Health Data Standards Committee.
Comments:	Lot/section numbers are generally used only until an area has been developed.

Most valid basis of diagnosis of cancer

Identifying and definitional attributes

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

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

Relational and representational attributes

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

Data domain:	0	Death Certificate Only: Information provided is from a death certificate.
	Non-microscopic	
	1	Clinical: Diagnosis made before death, but without any of the following (codes 2–7).
	2	Clinical investigation: All diagnostic techniques, including x-ray, endoscopy, imaging, ultrasound, exploratory surgery (e.g. laparotomy), and autopsy, without a tissue diagnosis.
	3	Specific tumour markers: Including biochemical and/or immunological markers that are specific for a tumour site.
	Microscopic	
	4	Cytology: Examination of cells from a primary or secondary site, including fluids aspirated by endoscopy or needle; also includes the microscopic examination of peripheral blood and bone marrow aspirates.
	5	Histology of metastasis: Histological examination of tissue from a metastasis, including autopsy specimens.
	6	Histology of a primary tumour: Histological examination of tissue from primary tumour, however obtained, including all cutting techniques and bone marrow biopsies; also includes autopsy specimens of primary tumour.
	7	Histology: either unknown whether of primary or metastatic site, or not otherwise specified.
	Other	
	9	Unknown.

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

revised if later information allows its upgrading.

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

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

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

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

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

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

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

Verification rules:

Collection methods:

Related metadata:

Information model link: NHIM   Physical wellbeing

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

Administrative attributes

Admin. status:	CURRENT	*Effective Date:*	25/02/04
Source organisation:	International Agency for Research on Cancer and International Association of Cancer Registries.		
Source document:			
Registration authority:	National Health Information Group.		

Steward:

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

Oestrogen receptor assay status

Identifying and definitional attributes

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

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

Relational and representational attributes

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

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

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

– the percentage of nuclei staining positive and the predominant staining intensity (low, medium, high) and

– a conclusion as to whether the assay is positive or negative

Verification rules:	
Collection methods:	
Related metadata:	
Information model link:	NHIM Assessment event

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

Administrative attributes

Admin. status:	CURRENT	*Effective Date:*	04/06/2004
Source organisation:	Royal College of Pathologists of Australasia		
	Australian Cancer Network		
	Commission on Cancer, American College of Surgeons		

Source document:	Royal College of Pathologists of *Australasia Manual of Use and Interpretation of Pathology Tests*: Third Edition Sydney (2001)
	Australian Cancer Network Working Party *The pathology reporting of breast cancer. A guide for pathologists, surgeons and radiologists* Second Edition Sydney (2001)
	Commission on Cancer, *Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS)* Volume II (1998)
Registration authority:	National Health Information Group.
Steward:	
Comments:	

Outcome of initial treatment

Identifying and definitional attributes

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

Metadata type: Data element

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

Relational and representational attributes

Data type: Numeric   *Maximum field size:*   3

Representational class: Code   *Format:*   N.N

Data domain:		
1.0	Complete response	
2.0	Incomplete response	
	2.1 Partial response	
	2.2 Stable or static disease	
	2.3 Progressive disease	
9.0	Not assessed or unable to be assessed	

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

Verification rules:

Collection methods:

Related metadata:

Information model link: NHIM   Exit/leave from service event

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

Administrative attributes

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

Source organisation: NSW Health Department.

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

Registration authority: National Health Information Group.

Steward:

Comments:

Postal delivery service number

Identifying and definitional attributes

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

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

Relational and representational attributes

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

Data domain:

Guide for use:	The identification of a postal delivery service may be composed of a Prefix a Number and a Suffix as per the following format:
	Prefix A(3)
	Number N(5)
	Suffix A(3)
	The identification may also not be required for certain services.
	Examples:
	PO BOX *C96*
	CARE PO
	RMB *123*
	GPO BOX *1777Q*
Verification rules:	
Collection methods:	To be collected in conjunction with Postal delivery service type abbreviation.
Related metadata:	Relates to Postal delivery service type — abbreviation, version 1.
	Relates to the data element Suburb/town/locality name, version 2.
	Relates to the data element Australian state/territory identifier, version 4.
	Relates to the data element Postcode — Australian, version 3.
Information model link:	NHIM Address element

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

Administrative attributes

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

Source organisation: Health Data Standards Committee.

Source document: AS4590 Interchange of client information.

Registration authority: National Health Information Group.

Steward: Health Data Standards Committee.

Comments:

Postal delivery service type — abbreviation

Identifying and definitional attributes

Knowledge base ID: **001017**   *Version number:*   *1*

Metadata type: Data element

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

Relational and representational attributes

Data type: Alphabetic   *Maximum field size:*   11

Representational class: Text   *Format:*   A(11)

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

Guide for use:

Verification rules:

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

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

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

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

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

Information model link: NHIM   Address element

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

Administrative attributes

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

Source organisation: Health Data Standards Committee.

Source document: AS4590 Interchange of client information.

Registration authority: National Health Information Group.

Steward: Health Data Standards Committee.

Comments:

Progesterone receptor assay status

Identifying and definitional attributes

Knowledge base ID:	***001072***	***Version number:***	***1***
Metadata type:	Data element		

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

Relational and representational attributes

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

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

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

  – the percentage of nuclei staining positive and the predominant staining intensity (low, medium, high) and

  – a conclusion as to whether the assay is positive or negatice

Verification rules:

Collection methods:

Related metadata:

Information model link:	NHIM	Assessment event

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

Administrative attributes

Admin. status:	CURRENT	*Effective Date:*	04/06/2004
Source organisation:	Royal College of Pathologists of Australasia.		
	Australian Cancer Network.		
	Commission on Cancer, American College of Surgeons.		

Source document:	Royal College of Pathologists of Australasia *Manual of Use and Interpretation of Pathology Tests*: Third Edition *Sydney (2001).*
	Australian Cancer Network Working Party *The pathology reporting of breast cancer. A guide for pathologists, surgeons and radiologists* Second Edition *Sydney (2001).*
	Commission on Cancer, *Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS)* Volume II *(1998).*
Registration authority:	National Health Information Group.
Steward:	
Comments:	

Radiotherapy treatment type

Identifying and definitional attributes

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

Metadata type: Data element

Definition:	The type of radiation therapy used in initial treatment of the cancer.
Context:	This item is collected for the analysis of outcome by treatment type.

Relational and representational attributes

Data type: Numeric *Maximum field size:* 1

Representational class: Code *Format:* N

Data domain:	0	No radiotherapy treatment given
	1	External beam radiation
	2	Brachytherapy (radioactive implants)
	3	Unsealed radioisotopes
	9	Radiotherapy was administered but method was not stated

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

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

Collection methods:

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

Relates to the data element Cancer initial treatment — starting date, version 1.

Relates to the data element Cancer initial treatment — completion date, version 1.

Relates to the data element Received radiation dose, version 1.

Information model link: NHIM Exit/leave from service event

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

Administrative attributes

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

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

NSW Health Department.

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

Reason for readmission—Acute coronary syndrome

Identifying and definitional attributes

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

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

Relational and representational attributes

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

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

Guide for use:	This data element is designed to identify recurrent admissions following an initial presentation with ACS, not necessarily to the hospital responsible for the index admission. The reason for readmission may be for cardiac or non-cardiac related causes.
	Code 5 is coded when a readmission and PCI is planned, i.e. not precipitated by a recurrent ischaemic event. If a recurrent ischaemic event precipitates a readmission with an associated PCI undertaken, one of codes 1–4 should be coded.
	Code 6 is coded when a readmission and CABG is planned, i.e. not precipitated by a recurrent ischaemic event. If a recurrent ischaemic event precipitates a readmission with an associated CABG undertaken, one of codes 1–4 should be coded.

Verification rules:

Collection methods:

Related metadata:	Is qualified by Acute coronary syndrome stratum, version 1
	Is qualified by the data element Concurrent clinical condition — on presentation, version 1
	Is used in conjunction with Heart rhythm type, version 1
	Is qualified by Separation date, version 5
	Is qualified by Date patient presents, version 2

Information model:	NHIM	Request for/entry into service event

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

Administrative attributes

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

Received radiation dose

Identifying and definitional attributes

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

Metadata type: Data element

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

Relational and representational attributes

Data type: Numeric   *Maximum field size:*   5

Representational class: Quantitative value   *Format:*   NNNNN

Data domain:	Valid numbers. Unit of measurement: Gy, or	
	00000	if no radiation therapy was administered
	99999	if radiation therapy was administered but the dose is unknown

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

Verification rules:

Collection methods:

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

Relates to the data element Radiotherapy treatment type, version 1.

Relates to the data element Cancer initial treatment — starting date, version 1.

Relates to the data element Cancer initial treatment — completion date, version 1.

Information model link: NHIM   Service provision event

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

Administrative attributes

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

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

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

Registration authority: National Health Information Group.

Steward:

Comments:

Referral from specialised mental health residential care

Identifying and definitional attributes

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

Definition:	The type of health care the resident is referred to by the residential care service for further care at the end of residential stay.
Context:	Specialised mental health services (Residential mental health care).

Relational and representational attributes

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

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

Guide for use:	Where the resident is referred to two or more types of health care, the type of health care provided by the service primarily responsible for the care of the resident is to be reported.
Verification rules:	
Collection methods:	
Related metadata:	
Information model link:	NHIM Exit/leave from service event

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

Administrative attributes

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

Source organisation:

Source document:

Registration authority: National Health Information Group.

Steward:

Comments:

Region of first recurrence

Identifying and definitional attributes

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

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

Relational and representational attributes

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

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

Guide for use:	The region of the first recurrence following the initial diagnosis should be recorded.
	The record should not be updated with subsequent recurrences.
	Record the highest numbered applicable response.
Verification rules:	
Collection methods:	
Related metadata:	Relates to the data element Date of diagnosis of first recurrence, version 1.
Information model link:	NHIM Physical wellbeing

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

Administrative attributes

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

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

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

Registration authority: National Health Information Group.

Steward:

Comments:

Regional lymph nodes examined

Identifying and definitional attributes

Knowledge base ID:	**001076**	*Version number:*	**1**
Metadata type:	Data element		

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

Relational and representational attributes

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

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

Guide for use:	Code 95	No regional lymph node(s) removed, but aspiration of regional lymph node(s) was performed, is used for a lymph node aspiration when cytology or histology is positive for malignant cells
	Code 99	Unknown; not stated; death certificate only, is used if information about regional lymph nodes is unknown or if the field is not applicable for that site or histology

Verification rules:

Collection methods:

Related metadata:	Relates to the data element Cancer staging − N stage code, version 1.
	Relates to the data element Regional lymph nodes positive, version 1.

Information model link:	NHIM	Service provision event

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

Administrative attributes

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

Source organisation: Australian Cancer Network.

Commission on Cancer, American College of Surgeons.

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

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

Registration authority: National Health Information Group.

Steward:

Comments:

Regional lymph nodes positive

Identifying and definitional attributes

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

Metadata type: Data element

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

Relational and representational attributes

Data type: Numeric   *Maximum field size:*   2

Representational class: Code   *Format:*   N(N)

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

Guide for use: Code 97   positive nodes but number not specified, is used when the cytology or hitology from a lymph node aspiration is positive for malignant cells.

                    Code 98   positive nodes but number not specified, is used when no nodes are removed or examined.

                    Code 99   unknown if nodes are positive or negative, is used if information about regional lymph nodes is unknown or if it is not applicable for that site or histology.

Verification rules:

Collection methods:

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

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

Information model link: NHIM   Physical wellbeing

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

   DSS —   Cancer (clinical)   04/06/2004

Administrative attributes

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

Source organisation: Australian Cancer Network.

Commission on Cancer, American College of Surgeons.

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

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

Registration authority: National Health Information Group.

Steward:

Comments:

Resident

Identifying and definitional attributes

Knowledgebase ID:	***000892***	*Version number:*	***1***
Metadata type:	Data element concept		

Definition:	A person who receives residential care intended to be for a minimum of one night.
Context:	Specialised mental health services (Residential mental health care).

Relational and representational attributes

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

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related metadata:

Information model link:	NHIM	Recipient role

Administrative attributes

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

Source organisation:

Source document:

Registration authority:	National Health Information Group.

Steward:

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

Residential mental health service

Identifying and definitional attributes

Knowledgebase ID:	*000899*	*Version number:*	*1*
Metadata type:	Data element concept		

Definition:	A residential mental health service is a specialised mental health service that: – employs mental health-trained staff on-site; – provides rehabilitation, treatment or extended care; • to residents provided with care intended to be on an overnight basis; • in a domestic-like environment; and – encourages the resident to take responsibility for their daily living activities. These services include those that employ mental health trained staff on-site 24 hours per day and other services with less intensive staffing. However all these services employ on-site mental health trained staff for some part of each day.
Context:	Specialised mental health services.

Relational and representational attributes

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

Data domain:

Guide for use:	
Verification rules:	
Collection methods:	
Related metadata:	Relates to the data element concept Specialised mental health service, version 1. Relates to the data element concept Resident, version 1.
Information model link:	NHIM Service delivery setting

Administrative attributes

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

Registration authority: National Health Information Group.

Steward:

Comments:

Residential stay

Identifying and definitional attributes

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

Definition:	The period of care beginning with a formal start of residential care and ending with a formal end of the residential care and accommodation. May involve more than one reference period, that is, more than one episode of residential care.
Context:	Specialised mental health services (Residential mental health care).

Relational and representational attributes

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

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related metadata:	Relates to the data element concept Episode of residential care, version 1.
	Relates to the data element concept Resident, version 1.
	Relates to the data element concept Episode of residential care end, version 1.
	Relates to the data element Episode of residential care end date, version 1.
	Relates to the data element Residential stay start date, version 1.
Information model link:	NHIM Service provision event

Administrative attributes

Admin. status:	CURRENT	*Effective Date:*	14/11/2003
Source organisation:			
Source document:			
Registration authority:	National Health Information Group.		
Steward:			
Comments:			

Residential stay start date

Identifying and definitional attributes

Knowledgebase ID:　　　***001001***　　*Version number:*　　***1***

Metadata type:　　　　　Data element

Definition:	Date on which a resident formally started a residential stay.
Context:	Specialised mental health services (Residential mental health care).

Relational and representational attributes

Data type:　　　　　　　　Numeric　　　*Maximum field size:*　　8

Representational class:　　Date　　　　*Format:*　　　　　　　　DDMMYYYY

Data domain:	Valid date.

Guide for use:

Verification rules:　　　　Right justified and zero filled.

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

　　　　　　　　　　　　　Residential stay start date must be greater than or equal to date of birth.

Collection methods:

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

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

　　　　　　　　　　　　　Relates to the data element concept Resident, version 1.

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

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

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

Administrative attributes

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

Source organisation:

Source document:

Registration authority:　　National Health Information Group.

Steward:

Comments:

Specialised mental health service

Identifying and definitional attributes

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

Metadata type: Data element concept

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

Relational and representational attributes

Data type: *Maximum field size:*

Representational class: *Format:*

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related metadata:	Relates to the data element Establishment identifier, version 1.
	Relates to the data element Establishment type, version 1.
	Relates to the data element concept Residential mental health services, version 1.
Information model link:	NHIM Service delivery setting

Administrative attributes

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

Source organisation:

Source document:

Registration authority: National Health Information Group.

Steward:

Comments:

Specialised mental health service setting

Identifying and definitional attributes

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

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

Relational and representational attributes

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

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

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

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

Code 1   Admitted patient care setting:

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

Code 2   Residential care setting:

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

Code 3   Ambulatory care setting:

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

Verification rules:

Collection methods:

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

Relates to the data element Establishment identifier, version 4.

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

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

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

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

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

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

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

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

Information model link: NHIM   Service delivery setting

Data set specifications:	*Start date*	*End date*
NMDS — Community mental health establishments	01/07/2004	

Administrative attributes

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

Source organisation:

Source document:

Registration authority: National Health Information Group.

Steward:

Comments: Only domain values 2, 3 and 9 are to be used for Community mental health establishments NMDS. Domain value 1 is not applicable.

Specialist private sector rehabilitation care indicator

Identifying and definitional attributes

Knowledge base ID: **001006**   *Version number:*   **1**

Metadata type: Data element

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

Relational and representational attributes

Data type: Numeric   *Maximum field size:*   1

Representational class: Code   *Format:*   N

Data domain:	1	Yes
	2	No

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

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

– provided by a specialist rehabilitation unit (a separate physical space and a specialist rehabilitation team providing admitted patient and/or ambulatory care) meeting guidelines issued by the Australian Government Department of Health and Ageing; and

– provided by a multi-disciplinary team which is under the clinical management of a consultant in rehabilitation medicine or equivalent; and

– provided for a person with limited functioning (impairments, activity limitation and participation restrictions) and for whom there is a reasonable expectation of functional gain; and

– for whom the primary treatment goal is improvement in functional status which is evidenced in the medical record by:

  • an individualised and documented initial and periodic assessment of functional ability, or

  • an individualised multi-disciplinary rehabilitation plan which includes agreed rehabilitation goals and indicative timeframes.

Verification rules:

Collection methods:

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

Information model link: NHIM   Assessment event

Administrative attributes

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

Source organisation: Private Rehabilitation Working Group

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

Registration authority: National Health Information Group.

Steward:

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

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

Staging basis

Identifying and definitional attributes

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

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

Relational and representational attributes

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

Data domain:	P	Pathological
	C	Clinical

Guide for use:	Clinical stage is based on evidence obtained prior to treatment from physical examination, imaging, endoscopy, biopsy, surgical exploration or other relevant examinations.
	Pathological stage is based on histological evidence acquired before treatment, supplemented or modified by additional evidence acquired from surgery and from pathological examination.
	Refer to the UICC reference manual *TNM Classification of Malignant Tumours* for coding rules.
Verification rules:	
Collection methods:	From information provided by the treating doctor and recorded on the patient's medical record.
Related metadata:	Relates to the data element Cancer staging — T stage code, version 1.
	Relates to the data element Cancer staging — N stage code, version 1.
	Relates to the data element Cancer staging — M stage code, version 1.
	Relates to the data element Cancer staging — TNM stage grouping code, version 1.
	Relates to the data element Staging scheme source, version 1.
	Relates to the data element Staging scheme edition number, version 1.
Information model link:	NHIM Physical wellbeing

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

Administrative attributes

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

Source organisation:　　　International Union Against Cancer (UICC).

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

Registration authority:　　　National Health Information Group.

Steward:

Comments:

Staging scheme source

Identifying and definitional attributes

Knowledgebase ID: *001080*   *Version number:*   *1*

Metadata type: Data element

Definition:	The staging scheme source is the reference which describes in detail the methods of staging and the definitions for the classification system used in determining the extent of cancer at the time of diagnosis.
Context:	For survival analysis adjusted by stage at diagnosis and distribution of cancer cases by type and stage.

Relational and representational attributes

Data type: Numeric   *Maximum field size:*   1

Representational class: Code   *Format:*   N

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

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

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

The current edition of each staging scheme should be used.

Verification rules:

Collection methods:

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

Is used in conjunction with data element Staging scheme source edition number, version 1.

Information model link: NHIM   Assessment event

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

Administrative attributes

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

Source organisation: International Union Against Cancer (UICC).

FAB (French-American-British) Group.

NSW Health Department.

National Health & Medical Research Council.

Clinical Oncological Society of Australia.

Australian Cancer Network.

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

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

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

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

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

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

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

Registration authority: National Health Information Group.

Steward:

Comments:

Staging scheme source edition number

Identifying and definitional attributes

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

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

Relational and representational attributes

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

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

Guide for use:

Verification rules:

Collection methods:

Related metadata:	Used in conjunction with the data element Staging scheme source, version 1.
Information model link:	NHIM Assessment event

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

Administrative attributes

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

Street name

Identifying and definitional attributes

Knowledgebase ID:	**001014**	*Version number:*	**1**
Metadata type:	Data element		

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

Relational and representational attributes

Data type:	Alphabetic	*Maximum field size:*	30
Representational class:	Text	*Format:*	A(30)

Data domain:	Free text.

Guide for use:	To be used in conjunction with Street type code.
	To be used in conjunction with Street suffix code.
Verification rules:	
Collection methods:	
Related metadata:	Relates to the data element Street Type Code, version 1.
	Relates to the data element Street Suffix Code, version 1.
	Relates to the data element House/Property Number, version 1.
	Is a composite part of the data element Address line, version 1.
Information model link:	NHIM Address element

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

Administrative attributes

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

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

Street suffix code

Identifying and definitional attributes

Knowledgebase ID: **001015**   *Version number:*   **1**

Metadata type: Data element

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

Relational and representational attributes

Data type: Alphabetic   *Maximum field size:*   2

Representational class: Text   *Format:*   A(2)

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

Guide for use:

Verification rules:

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

To be used in conjunction with Street type code.

For example:

   Browns Rd W.

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

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

Relates to the data element House/property number, version 1.

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

Information model link: NHIM   Address element

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

Administrative attributes

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

Source organisation: Health Data Standards Committee.

Source document: AS4590 Interchange of client information.
Australia Post Address Presentation Standard.

Registration authority: National Health Information Group.

Steward: Health Data Standards Committee.

Comments:

Street type code

Identifying and definitional attributes

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

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

Relational and representational attributes

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

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

Guide for use:

Verification rules:

Collection methods:	To be collected in conjunction with Street name.
	To be collected in conjunction with Street suffix code.
Related metadata:	Is a composite part of the data element Address line, version 1.
Information model link:	NHIM Address element

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

Administrative attributes

Admin. status:	CURRENT	*Effective Date:*	25/02/2004
Source organisation:	Standards Australia.		
	Health Data Standards Committee.		
Source document:	AS4590 Interchange of client information.		
	Australia Post Address Presentation Standard.		
Registration authority:	National Health Information Group.		
Steward:	Health Data Standards Committee.		
Comments:	The following is a list of commonly used abbreviations from AS 4590:		

      Street type Abbreviation

Street type	Abbreviation
Alley	Ally
Arcade	Arc
Avenue	Ave

Comments
(continued):

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

Surgical treatment procedure for cancer

Identifying and definitional attributes

Knowledgebase ID: *001082*   *Version number:*   *1*

Metadata type: Data element

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

Relational and representational attributes

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

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

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

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

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

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

Verification rules:

Collection methods:

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

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

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

Information model link: NHIM   Physical wellbeing

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

Administrative attributes

Admin. status:	CURRENT	*Effective Date:*	04/06/2004
Source organisation:	National Centre for Classification in Health.		
	NSW Department of Health, Public Health Division.		

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

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

Registration authority: National Health Information Group.

Steward:

Comments:

Systemic therapy agent name

Identifying and definitional attributes

Knowledgebase ID: **001083**   *Version number:*   **1**

Metadata type: Data element

Definition:	The standard chemotherapeutic agent or anti-cancer drug used for treatment of the primary cancer.
Context:	This item is collected for the analysis of outcome by treatment type. Collecting dates for systemic therapy will allow evaluation of treatments delivered and of time intervals from diagnosis to treatment, from treatment to recurrence and from treatment to death.

Relational and representational attributes

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

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

Guide for use:	The purpose of collecting specific treatment information is to account for all treatment types, which may assist in evaluation of effectiveness of different treatment patterns. The actual agents used will sometimes be of interest. Systemic therapy often involves treatment with a combination of agents. These may be known by acronyms but since details of drugs and acronyms may vary it is recommended that each agent be recorded separately. Oral chemotherapy normally given on an outpatient basis should also be included. New codes and names will need to be added as new agents become available for clinical use. Hormone therapy agents and immunotherapy agents should be recorded under this data element.
Verification rules:	
Collection methods:	The full name of the agent(s) should be recorded if the coding manual is not available.
Related metadata:	Relates to the data element Initial treatment episode for cancer, version 1. Relates to the data element Cancer initial treatment — starting date, version 1. Relates to the data element Cancer initial treatment — completion date, version 1.
Information model link:	NHIM Service provision event

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

Administrative attributes

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

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

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

Registration authority: National Health Information Group.

Steward:

Comments:

Time creatine kinase MB isoenzyme (CK-MB) measured

Identifying and definitional attributes

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

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

Relational and representational attributes

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

Data domain:	Time in 24-hour clock format.

Guide for use:	
Verification rules:	
Collection methods:	
Related metadata:	Is used in conjunction with Creatine kinase MB isoenzyme (CK-MB) — measured, version 1
	Is used in conjunction with Date Creatine kinase MB isoenzyme (CK-MB) measured, version 1
Information model:	NHIM Service provision event

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

Administrative attributes

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

Time of first angioplasty balloon inflation or stenting

Identifying and definitional attributes

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

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

Relational and representational attributes

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

Data domain:	Time in 24-hour clock format.

Guide for use:	For Acute coronary syndrome (ACS) reporting, refers to coronary arteries.
Verification rules:	
Collection methods:	
Related metadata:	Is used in conjunction with the data element Date of first angioplasty balloon inflation or stenting, version 1.
	Is used in conjunction with the data element Date of triage, version 1.
	Is used in conjunction with the data element Time of triage, version 1.
	Is used in conjunction with the data element Acute coronary syndrome procedure type, version 1.
Information model:	NHIM Service provision event

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

Administrative attributes

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

Time of intravenous fibrinolytic therapy

Identifying and definitional attributes

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

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

Relational and representational attributes

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

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

Guide for use:	For Acute coronary syndrome (ACS) reporting, refers to coronary arteries. If initiated by a bolus dose whether in a pre-hospital setting, emergency department or inpatient unit/ward, the time the initial bolus was administered should be reported.
Verification rules:	
Collection methods:	
Related metadata:	Is used in conjunction with the data element Fibrinolytic therapy status, version 1.
	Is used in conjunction with the data element Date of intravenous fibrinolytic therapy, version 1.
	Is used in conjunction with the data element Fibrinolytic drug used, version 1.
	Is used in conjunction with the data element Date of triage, version 1.
	Is used in conjunction with the data element Time of triage, version 1.
Information model:	NHIM Service provision event

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

Administrative attributes

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

Time troponin measured

Identifying and definitional attributes

Knowledge base ID:	**001051**	*Version number:*	**1**
Metadata type:	Data element		

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

Relational and representational attributes

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

Data domain:	Time in 24-hour clock format.

Guide for use:	This data element pertains to the measuring of troponin at any time point during this current event.
Verification rules:	
Collection methods:	
Related metadata:	Is used in conjunction with the data element Date troponin measured, version 1.
	Is used in conjunction with the data element Troponin measured, version 1.
Information model:	NHIM Service provision event

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

Administrative attributes

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

Troponin assay type

Identifying and definitional attributes

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

Definition:	Identifies the type of troponin assay (I or T) used to assess the person's troponin levels.
Context:	Health care and clinical settings.

Relational and representational attributes

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

Data domain:	1	Cardiac troponin T (cTnT)
	2	Cardiac troponin I (cTnI)
	8	Not taken
	9	Not stated/inadequately described

Guide for use:	For Acute coronary syndrome (ACS) reporting, identifies the type of troponin assay (I or T) used to assess troponin levels during this presentation.
Verification rules:	
Collection methods:	
Related metadata:	Is used in conjunction with the data element Troponin measured, version 1.
	Is used in conjunction with the data element Troponin assay—upper limit of normal range, version 1.
	Is used in conjunction with the data element Time troponin measured, version 1.
	Is used in conjunction with the data element Date troponin measured, version 1.
Information model:	NHIM Service provision event

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

Administrative attributes

Admin. status:	CURRENT	*Effective Date:*	04/06/2004
Source organisation:	Acute Coronary Syndrome Data Working Group.		
Source document:			
Registration authority:	National Health Information Group.		

Steward: The National Heart Foundation of Australia.

                                 The Cardiac Society of Australia and New Zealand.

Comments:

Troponin assay — upper limit of normal range

Identifying and definitional attributes

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

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

Relational and representational attributes

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

Data domain:	µg/L upper limit value that is constant for the laboratory performing the test
	9999 Not stated/Inadequately described.

Guide for use:	Record the upper limit of normal (usually the ninety-ninth percentile of a normal population) for the individual laboratory.
Verification rules:	
Collection methods:	
Related metadata:	Is used in conjunction with Troponin measured, version 1
	Is used in conjunction with Troponin — assay type, version 1.
	Is used in conjunction with Time troponin measured, version 1.
	Is used in conjunction with Date troponin measured, version 1.
Information model:	NHIM Service provision event

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

Administrative attributes

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

Troponin measured

Identifying and definitional attributes

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

Definition:	A person's measured troponin.
Context:	Health care and clinical settings.

Relational and representational attributes

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

Data domain:	Troponin measured in µg/L, or
	8888 Not measured
	9999 Not stated/ inadequately defined

Guide for use:	Code 8888 if test for troponin (T or I) was not done.
	Measured in different assays dependant upon laboratory methodology.
	When only one troponin level is recorded, this should be the peak level during the admission.
	For Acute coronary syndrome (ACS) reporting, can be used to determine diagnostic strata.
Verification rules:	
Collection methods:	
Related metadata:	Is a qualifier of the data element Acute coronary syndrome stratum, version 1.
	Is used in conjunction with the data element Date troponin measured, version 1.
	Is used in conjunction with the data element Time troponin measured, version 1.
	Is used in conjunction with the data element Troponin — assay type, version 1.
	Is used in conjunction with the data element Troponin assay — upper level of normal, version 1.
Information model:	NHIM Service provision event

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

Administrative attributes

Admin. status:	CURRENT	*Effective Date:*	04/06/2004
Source organisation:	Acute Coronary Syndrome Data Working Group.		

Source document:

Registration authority: National Health Information Group

Steward: The National Heart Foundation of Australia.

    The Cardiac Society of Australia and New Zealand.

Comments:

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.

Activity when injured

Identifying and definitional attributes

Knowledgebase ID: *000002*   *Version number:*   *3*

Metadata type: Data element

Definition:	The type of activity being undertaken by the person when injured.
Context:	Injury surveillance: enables categorisation of injury and poisoning according to factors important for injury control. Necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research. This item is the basis for identifying work-related and sport-related injuries.

Relational and representational attributes

Data type:	Numeric; Alphanumeric for admitted patients	*Maximum field size:*	2; 5 for admitted patients
Representational class:	Code	*Format:*	N(N); ANNNN for admitted patients

Data domain:

Non-admitted patients:

0   Sports activity

    00   Football, rugby

    01   Football, Australian

    02   Football, soccer

    03   Hockey

    04   Squash

    05   Basketball

    06   Netball

    07   Cricket

    08   Roller blading

    09   Other and unspecified sporting activity

1   Leisure activity (excluding sporting activity)

2   Working for income

3   Other types of work

4   Resting, sleeping, eating or engaging in other vital activities

5   Other specified activities

6   Unspecified activities

Admitted patients:

Use the appropriate External Causes of Morbidity and Mortality Activity codes from the current edition of ICD-10-AM. Used with ICD-10-AM external cause codes and assigned according to the Australian Coding Standards.

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

Knowledge base 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.

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

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 — 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

Data set specifications:	*Start date*	*End date*
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	Triplets
	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:
	— 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.

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.

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.

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'.

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*

<table>
<tr><td></td><td>*Countries* 1998 (SACC). Cat. no. 1269.0. Canberra: ABS.</td></tr>
<tr><td></td><td>Reference through:
<http://www.abs.gov.au/Ausstats/abs@.nsf/StatsLibrary></td></tr>
<tr><td>*Registration authority:*</td><td>National Health Information Group.</td></tr>
<tr><td></td><td>National Community Services Information Management Group.</td></tr>
<tr><td>*Steward:*</td><td></td></tr>
<tr><td>*Comments:*</td><td>This metadata item is common to both the *National Health Data Dictionary* and the *National Community Services Data Dictionary*.</td></tr>
<tr><td></td><td>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.</td></tr>
<tr><td></td><td>The Standard Australian Classification of Countries (SACC) supersedes the Australian Standard Classification of Countries for Social Statistics (ASCCSS).</td></tr>
</table>

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.

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

Knowledge base 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.

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

Knowledge base 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.

275

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:

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.

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

Knowledge base 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.

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.

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 know 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 use 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:	*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 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.

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 *National Health Data Dictionary* and the *National Community Services Data Dictionary*.

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 *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*.

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 *International Classification of Diseases* — Tenth Revision — Australian Modification. National Centre for Classification in Health, Sydney.		
Registration authority:	National Health Information Group.		
Steward:			
Comments:	The list of indicator procedures may be reviewed from time to time. Some health authorities already code a larger number of waiting list procedures.		

The following is a list of ICD-10-AM codes, for the indicator procedures:

Cataract extraction:

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]

Cholecystectomy:

30443-00 [965] 30454-01 [965] 30455-00 [965] 30445-00 [965] 30446-00 [965] 30448-00 [965] 30449-00 [965]

Coronary artery bypass graft:

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]

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:	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.
	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.
Context:	Ageing, disability and health.
	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.

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:	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.
	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.
	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).
	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.
	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

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:	*Start date*	*End date*
DSS — Cardiovascular disease (clinical)	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 orce:

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:	*Start date*	*End date*
DSS — Cardiovascular disease (clinical)	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. *Directory of Concepts and Standards for Social, Labour and Demographic Variables. Australia* 1995. 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 *National Health Data Dictionary* and the *National Community Services Data Dictionary*.

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:	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).
	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.

Relational and representational attributes

Data type: Numeric   *Maximum field size:*   4

Representational class: Code   *Format:*   NNNN

Data domain:	Valid codes from ABS *Australian Standard Classification of Languages*, 1997, ABS Cat. No. 1267.0
Guide for use:	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.
	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.
	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.
	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

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. *Australian Standard Classification of Language* (ASCL), 1997. Cat. no. 1267.0. Canberra: ABS. Reference through: <http://www.abs.gov.au/Ausstats/abs@.nsf/StatsLibrary>.

Australian Bureau of Statistics 1999. *Standards for Statistics on Cultural and Language Diversity* 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.
	NHDD specific:
	NMDS — Injury surveillance:
	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.

Relational and representational attributes

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

Data domain:	Valid codes from the *Australian Standard Classification of Occupations*, Second edition 1997 (ABS Cat. no. 1220.0). Reference through:
	<http://www.abs.gov.au/Ausstats/abs@.nsf/StatsLibrary>.
	Select: ABS Classifications.

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:	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.
	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.

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:	This data element collects information on social marital status. The recommended question module is:

Do you/Does the person usually live with a partner in a registered or de facto marriage?

> Yes, in a registered marriage
>
> Yes, in a defacto marriage
>
> No, never married
>
> No, separated
>
> No, divorced
>
> No, widowed

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.

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.

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.

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:	*Start date*	*End date*
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*.		

Name context flag

Identifying and definitional attributes

Knowledgebase ID:	***002016***	*Version number:*	***2***
Metadata type:	Data element		

Definition:	An indicator of specific conditions that may be applied to a particular person's name.
Context:	

Relational and representational attributes

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

Data domain:	1	Unreliable information
	2	Name not for continued use
	3	Special privacy/security requirement

Guide for use:	Code 1	Unreliable information, should be used where it is known that the name recorded is a fictitious or partial name. These names should not be used for matching client data.
	Code 2	Name not for continued use, includes certain tribal names which may not be appropriate for long term use.
	Code 3	Special privacy/security requirements, may apply to names for which episodes are attached that should only be accessible to specified authorised persons. There must be a specific need to implement this additional security level. Local policy should provide guidance to the use of this code.

Verification rules:	
Collection methods:	
Related metadata:	Supersedes the previous data element Name context flag, version 1.
	Relates to the data element concept Name, version 1.
Information model link:	NHIM　　　Person characteristic

		Start date	*End date*
Data set specifications:			
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:	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 *National Health Data Dictionary* and the *National Community Services Data Dictionary*.

Name suffix

Identifying and definitional attributes

Knowledgebase ID:	**002017**	*Version number:*	**2**
Metadata type:	Data element		

Definition:	Additional term following a person's name used to identify a person when addressing them by name, whether by mail, by phone, or in person.
Context:	

Relational and representational attributes

Data type:	Alphabetic	*Maximum field size:*	12
Representational class:	Text	*Format:*	A(12)

Data domain:	Valid abbreviations from the Australian Standard AS4590—1999 Interchange of client information.

Guide for use:	Mixed case should be used (rather than upper case only).
Verification rules:	
Collection methods:	More than one Name suffix may be collected. Use a single space between each suffix.
	Examples of Name suffixes are 'Jr' for Junior and 'MP' for Member of Parliament.
Related metadata:	Supersedes previous data element Name suffix, 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 — 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:	Standards Australia 1999. Australian Standard AS4590—1999 Interchange of Client Information. Sydney: Standards Australia.		
	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 *National Health Data Dictionary* and the *National Community Services Data Dictionary*.

Name title

Identifying and definitional attributes

Knowledgebase ID:	**002018**	*Version number:*	**2**
Metadata type:	Data element		

Definition:	An honorific form of address, commencing a name, used when addressing a person by name, whether by mail, by phone, or in person.
Context:	

Relational and representational attributes

Data type:	Alphabetic	*Maximum field size:*	12
Representational class:	Text	*Format:*	A(12)

Data domain:	Valid abbreviations from the Australian Standard AS4590—1999 Interchange of client information.

Guide for use:	Name title should not be confused with job title.
	Mixed case should be used (rather than upper case only).
	An example of Name title is 'Mr' for Mister.
Verification rules:	The Name title for Master should only be used for persons less than 15 years of age.
	Name titles for Doctor and Professor should only be applicable to persons of greater than 20 years of age.
Collection methods:	
Related metadata:	Supersedes the previous data element Name title, version 1.
	Relates to the data element concept Name, version 1.
Information model link:	NHIM Social 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:	Standards Australia 1999. Australian Standard AS4590—1999 Interchange of Client Information. Sydney: Standards Australia.		
	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 *National Health Data Dictionary* and the *National Community Services Data Dictionary*.

Neonatal morbidity

Identifying and definitional attributes

Knowledgebase ID:	***000102***	*Version number:*	***2***
Metadata type:	Data element		

Definition:	Conditions or diseases of the baby.
Context:	Perinatal statistics:
	Morbidity of a baby is an important determinant of outcome and duration of hospital stay.

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.

Guide for use:	There is no arbitrary limit on the number of conditions specified.
Verification rules:	Conditions should be coded within chapter of Volume 1, ICD-10-AM.
Collection methods:	
Related metadata:	Supersedes the previous data element Neonatal morbidity — ICD-9-CM code, version 1.
	Is used in conjunction with the data element Congenital malformations — BPA code, version 1.
	Is used in conjunction with the data element Congenital malformations, 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:			

Other drug of concern

Identifying and definitional attributes

Knowledgebase ID: **000442**   *Version number:*   **3**

Metadata type: Data element

Definition:	A drug apart from the Principal drug of concern which the client states as being a concern.
Context:	Alcohol and other drug treatment services. This item complements Principal drug of concern. The existence of other drugs of concern may have a role in determining the types of treatment required and may also influence treatment outcomes.

Relational and representational attributes

Data type: Numeric   *Maximum field size:*   4

Representational class: Code   *Format:*   NNNN

Data domain:	The Australian Standard Classification of Drugs of Concern (ASCDC). ABS Cat. No. 1248.0 (2000). (Plus 2 supplementary codes: code 0005 'opioid analgesics nfd' and code 0006 'psychostimulants nfd'.)

Guide for use: Record each additional drug of concern (according to the client) relevant to the treatment episode. The other drug of concern does not need to be linked to a specific treatment type.

The ASCDC provides a number of supplementary codes that have specific uses and these are detailed within the ASCDC, e.g. 0000 = inadequately described.

Other supplementary codes that are not already specified in the ASCDC may be used in NMDS's when required. In the AODTS NMDS two additional supplementary codes have been created which enable a finer level of detail to be captured:

Code 0005 ' opioid analgesics not further defined' (nfd) is to be used when it is known that the client's Principal drug of concern is an opioid but the specific opioid used is not known. The existing code 1000 combines opioid analgesics and non-opioid analgesics together into Analgesics nfd and the finer level of detail, although known, is lost.

Code 0006 ' psychostimulants nfd' is to be used when it is known that the client's Principal drug of concern is a psychostimulant but not which type. The existing code 3000 combines stimulants and hallucinogens together into Stimulants and hallucinogens nfd and the finer level of detail, although known, is lost.

Verification rules: There should be no duplication with Principal drug of concern.

Collection methods: More than one drug may be selected.

Any other drug of concern for the client should be recorded upon commencement of a treatment episode.

For clients whose treatment episode is related to the alcohol and other drug use of another person, this data element should not be collected.

Related metadata:	Supersedes the previous data element Other drug of concern, version 2.
	Relates to the data element Principal drug of concern, version 3.
	Is qualified by the data element Client type — alcohol and other drug treatment services, version 3.
	Relates to the data element Other treatment type for alcohol and other drugs, version 1.
Information model link:	NHIM Physical wellbeing

Data set specifications:	Start date	End date
NMDS — Alcohol and other drug treatment services	01/07/2004	

Administrative attributes

Admin. status:	CURRENT	*Effective Date:*	14/11/2003
Source organisation:	Intergovernmental Committee on Drugs National Minimum Data Set Working Group.		
Source document:			
Registration authority:	National Health Information Group.		
Steward:			
Comments:			

Other treatment type for alcohol and other drugs

Identifying and definitional attributes

Knowledgebase ID:	**000642**	*Version number:*	**1**
Metadata type:	Data element		

Definition:	All other forms of treatment provided to the client in addition to the data element Main treatment type for alcohol and other drugs.
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	Other

Guide for use:	To be completed at cessation of treatment episode.
	Only report treatment recorded in the client's file that is in addition to, and not a component of, the Main treatment type for alcohol and other drugs. Treatment activity reported here is not necessarily for Principal drug of concern in that it may be treatment for Other drugs of concern.
	Code 1 Withdrawal management (detoxification), refers to any form of withdrawal management, including medicated and non-medicated.
	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 selection 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 clients who are on an opioid pharmacotherapy maintenance program and are not receiving any other form of treatment.

Verification rules:

Collection methods: More than one code may be selected. This field should be left blank if there are no other treatment types for the episode.

Related metadata: Relates to data element Main 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:

Outcome of last previous pregnancy

Identifying and definitional attributes

Knowledgebase ID:	*000114*	*Version number:*	*1*
Metadata type:	Data element		

Definition:	Outcome of the most recent pregnancy preceding this pregnancy.
Context:	Perinatal statistics:
	Adverse outcome in previous pregnancy is an important risk factor for subsequent pregnancy.

Relational and representational attributes

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

Data domain:	1	Single live birth — survived at least 28 days
	2	Single live birth — neonatal death (within 28 days)
	3	Single stillbirth
	4	Spontaneous abortion
	5	Induced abortion
	6	Ectopic pregnancy
	7	Multiple live birth — all survived at least 28 days
	8	Multiple birth — one or more neonatal deaths (within 28 days) or stillbirths

Guide for use:	In the case of multiple pregnancy with fetal loss before 20 weeks, code on outcome of surviving fetus(es) beyond 20 weeks.
Verification rules:	
Collection methods:	
Related metadata:	Is a qualifier of the data element Date of completion of last previous pregnancy, version 1.
Information model link:	NHIM Physical wellbeing

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:	This data item is recommended by the World Health Organization. It is collected in some states and Territories.		

Person identifier

Identifying and definitional attributes

Knowledgebase ID:	**002020**	*Version number:*	**2**
Metadata type:	Data element		

Definition:	Person identifier unique within an establishment or agency.
Context:	This item could be used for editing at the agency, establishment or collection authority level and, potentially, for episode linkage. There is no intention that this item would be available beyond collection authority level.

Relational and representational attributes

Data type:	Alphanumeric	*Maximum field size:*	20
Representational class:	Identification number	*Format:*	AN(20)

Data domain:	Valid person identification number.

Guide for use:	Individual agencies, establishments or collection authorities may use their own alphabetic, numeric or alphanumeric coding systems.
Verification rules:	Field cannot be blank.
Collection methods:	
Related metadata:	Supersedes the previous data element Person identifier, version 1.
	Is qualified by Person identifier type — health care, version 1.
Information model link:	NHIM Recipient role

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 —	Cancer (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: 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*.

Place of occurrence of external cause of injury

Identifying and definitional attributes

Knowledgebase ID:	**000384**	*Version number:*	**6**
Metadata type:	Data element		

Definition:	The place where the external cause of injury, poisoning or adverse effect occurred.
Context:	Enables categorisation of injury and poisoning according to factors important for injury control. Necessary for defining and monitoring injury control targets, injury costing and identifying cases for in-depth research.

Relational and representational attributes

Data type:	Numeric; Alphanumeric for admitted patients	*Maximum field size:*	2; 5 for admitted patients
Representational class:	Code	*Format:*	N(N); ANNNN for admitted patients

Data domain:	0	Home	
	1	Residential Institution	
	2	School, other institution and public administration area	
		21	School
		22	Health service area
		23	Building used by general public or public group
	3	Sports and athletics area	
	4	Street and highway	
	5	Trade and service area	
	6	Industrial and construction area	
	7	Farm	
	8	Other specified places	
	9	Unspecified place	
	Admitted patients:		
	Use External Causes of Morbidity and Mortality Place of Occurrence codes from the current edition of ICD-10-AM. Used with all ICD-10-AM external cause codes and assigned according to the Australian Coding Standards.		

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 place where the person was situated when the injury occurred 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:	Supersedes previous data element Place of occurrence of external cause of injury — admitted patient, version 5.
	Is used in conjunction with the data element External cause — admitted patient, 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 Other setting

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:*	04/06/2004
Source organisation:	Health Data Standards Committee.		
	National Centre for Classification in Health.		
	AIHW National Injury Surveillance Unit.		
	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:			

Postal delivery point identifier

Identifying and definitional attributes

Knowledgebase ID:	**002022**	*Version number:*	**2**
Metadata type:	Data element		

Definition:	A unique number assigned to a postal address as recorded on the Australia Post Postal Address File (PAF).
Context:	

Relational and representational attributes

Data type:	Numeric	*Maximum field size:*	8
Representational class:	Code	*Format:*	N(8)

Data domain:	Valid Postal Delivery Point Identifier (PDPID) Code or blank.

Guide for use:	Australia Post maintains a Postal Address File (PAF) database which contains Australian postal delivery addresses and their corresponding eight (8) character unique identification number known as a Delivery Point Identifier (DPID). While the PAF is concerned with postal address, for many persons' a postal address will be the same as their residential address. The PAF can be used to improve the recording of address data at the time of data entry.
	The Postal Address File may be used at the time of data entry to confirm that the combined data elements of Address line, Suburb/town/locality name, Australian state/territory identifier and Postcode — Australian are accurately recorded.
Verification rules:	Field may be blank (where the person's address is not a recognised Australia Post delivery address).
Collection methods:	The DPID is assigned electronically to recognised Australia Post delivery addresses following reference to the PAF database.
Related metadata:	Supersedes the previous data element Postal delivery point identifier, version 1.
Information model link:	NHIM Address element

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:	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 *National Health Data Dictionary* and the *National Community Services Data Dictionary*.

In October 1999, Australia Post introduced a bar-coding system for bulk mail lodgements. Agencies or establishments can use software to improve the quality of person address data it collects and records and, at the same time, receive financial benefits by reducing its postage expenses.

The DPID is easily converted to a bar code and can be included on correspondence and address labels. If the bar code is displayed on a standard envelope that passes through a mail-franking machine (e.g. as used by most major hospitals), the postage cost is reduced.

Every three months, Australia Post provides updates to the PAF database. For more information, contact Australia Post.

Postcode — Australian

Identifying and definitional attributes

Knowledgebase ID: **002021** *Version number:* **3**

Metadata type: Data element

Definition:	The numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of a party (person or organisation), as defined by Australia Post.
Context:	Postcode is an important part of a person's or organisation's postal address and facilitates written communication. It is one of a number of geographic identifiers that can be used to determine a geographic location. Postcode may assist with uniquely identifying a person or organisation.

Relational and representational attributes

Data type: Numeric *Maximum field size:* 4

Representational class: Code *Format:* NNNN

Data domain:	Valid Australia Post postal code.

Guide for use: The postcode book is updated more than once annually as postcodes are a dynamic entity and are constantly changing.

Verification rules:

Collection methods: May be collected as part of Address or separately.

Postal addresses may be different from where a person actually resides, or a service is actually located.

Leave Postcode — Australian blank for:

– Any overseas address

– Unknown address

– No fixed address.

Related metadata: Supersedes previous data element Australian postcode, version 1.

Information model link: NHIM   Address element

Data set specifications:	*Start date*	*End date*
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:	Standards Australia.
	Health Data Standards Committee.
	National Community Services Data Committee.
Source document:	Standards Australia 2002. Australian Standard AS5017 — 2002 Health Care Client Identification. Sydney: Standards Australia.
	Australia Post Postcode book. Reference through:
	<http://www1.auspost.com.au/postcodes/>.
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*.

Comments (continued):

Postcode may be used in the analysis of data on a geographical basis, which involves a conversion from postcodes to the ABS postal areas. This conversion results in some inaccuracy of information. However, in some data sets postcode is the only geographic identifier, therefore the use of other more accurate indicators (e.g. Statistical Local Area) is not always possible.

When dealing with aggregate data, postal areas, converted from postcodes, can be mapped to ASGC codes using an ABS concordance, for example to determine SLAs. It should be noted that such concordances should not be used to determine the SLA of any individual's postcode. Where individual street addresses are available, these can be mapped to ASGC codes (e.g. SLAs) using the ABS National Localities Index (NLI). Refer to ABS Catalogue No. 1252.0 for full details of the NLI.

NHDD specific:

DSS Cardiovascular disease (clinical):

Postcode can also be used in association with the Australian Bureau of Statistics Socio-Economic Indexes for Areas (SEIFA) index (Australian Bureau of Statistics Socio-Economic Indexes for Areas (SEIFA), Australia — CD-ROM Latest Issue: Aug 1996 was released on 30/10/1998) to derive socio-economic disadvantage, which is associated with cardiovascular risk.

People from lower socio-economic groups are more likely to die from cardiovascular disease than those from higher socio-economic groups. In 1997, people aged 25–64 living in the most disadvantaged group of the population died from cardiovascular disease at around twice the rate of those living in the least disadvantaged group (Australian Institute of Health and Welfare (AIHW) 2001. Heart, stroke and vascular diseases—Australian facts 2001.).

This difference in death rates has existed since at least the 1970s.

Postpartum complication

Identifying and definitional attributes

Knowledgebase ID:	**000131**	*Version number:*	**2**
Metadata type:	Data element		

Definition:	Medical and obstetric complications of the mother occurring during the postnatal period up to the time of separation from care.
Context:	Perinatal statistics:
	Complications of the puerperal period may cause maternal morbidity, and occasionally death, and may be an important factor in prolonging the duration of hospitalisation after childbirth.

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.

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 the previous data element Postpartum complication—ICD-9-CM code, version 1.
	Is used in conjunction with the data element Complication of labour and delivery, 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:	Examples of such conditions include postpartum haemorrhage, retained placenta, puerperal infections, puerperal psychosis, essential hypertension, psychiatric disorders, diabetes mellitus, epilepsy, cardiac disease and chronic renal disease.		

Pregnancy — current status

Identifying and definitional attributes

Knowledgebase ID:	**000842**	*Version number:*	**1**
Metadata type:	Data element		

Definition:	Whether a female person is currently pregnant.
Context:	Public health, health care and clinical settings.

Relational and representational attributes

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

Data domain:	1	Yes, currently pregnant
	2	No, not currently pregnant
	3	Not stated/ inadequately described

Guide for use:	Record whether or not the female individual is currently pregnant.
Verification rules:	
Collection methods:	Ask the individual if she is currently pregnant.
Related metadata:	Relates to the data element Diabetes status, version 1.
	Relates to the data element Health professionals attended — diabetes mellitus, version 1.
Information model link:	NHIM Physical wellbeing

Data set specifications:		*Start date*	*End date*
DSS — Diabetes (clinical)		01/01/2003	

Administrative attributes

Admin. status:	CURRENT	*Effective Date:*	01/01/2003
Source organisation:	National Diabetes Data Working Group.		
Source document:	*National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.*		
Registration authority:	National Health Information Group.		
Steward:			
Comments:	Pregnancy in women with pre-existing diabetes is a potentially serious problem for both the mother and fetus. Good metabolic control and appropriate medical and obstetric management will improve maternal and fetal outcomes. The diagnosis or discovery of diabetes in pregnancy (gestational diabetes), identifies an at risk pregnancy from the fetal		

perspective, and identifies the mother as at risk for the development of type 2 diabetes later in life.

Following Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus diabetes management during pregnancy includes:

- – routine medical review every 2–3 weeks during the first 30 weeks and then every 1–2 weeks until delivery;
- – monitor HbA1c every 4–6 weeks or more frequently if indicated to ensure optimal metabolic control during pregnancy;
- – advise patients to monitor blood glucose frequently and urinary ketones;
- – initial assessment and on going monitoring for signs or progression of diabetes complications;
- – regular routine obstetric review based on the usual indicators.

Management targets:

- – Blood glucose levels
  - • Fasting <5.5 mmol/L
  - • Post-prandial < 8.0 mmol/L at 1 hour, < 7mmol/L at 2 hours.
- – HbA1c levels within normal range for pregnancy. (The reference range for HbA1c will be lower during pregnancy)
- – The absence of any serious or sustained ketonuria.

Normal indices for fetal and maternal welfare. Oral hypoglycaemic agents are contra-indicated during pregnancy and therefore women with pre-existing diabetes who are treated with oral agents should ideally be converted to insulin prior to conception.

What to do if unsatisfactory metabolic control:

- – Explore reasons for unsatisfactory control such as diet, intercurrent illness, appropriateness of medication, concurrent medication, stress, and exercise, and review management.
- – Review and adjust treatment.
- – Consider referral to diabetes educator, dietitian, endocrinologist or physician experienced in diabetes care, or diabetes centre.

Presentation at birth

Identifying and definitional attributes

Knowledgebase ID: **000133**   *Version number:*   **1**

Metadata type: Data element

Definition:	Presenting part of the fetus (at lower segment of uterus) at birth.
Context:	Perinatal statistics:
	Presentation types other than vertex are associated with higher rates of caesarean section, instrumental delivery, perinatal mortality and neonatal morbidity.

Relational and representational attributes

Data type: Numeric   *Maximum field size:*   1

Representational class: Code   *Format:*   N

Data domain:	1	Vertex
	2	Breech
	3	Face
	4	Brow
	5	Other
	9	Not stated

Guide for use:

Verification rules:

Collection methods:

Related metadata: Is used in conjunction with the data element Method of birth, version 1.

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:

Registration authority: National Health Information Group.

Steward:

Comments:

Previous pregnancies

Identifying and definitional attributes

Knowledgebase ID: **000134**   ***Version number:***   ***1***

Metadata type: Data element

Definition:	The total number of previous pregnancies, specified as pregnancies resulting in:
	— live birth, or
	— stillbirth — at least 20 weeks' gestational age or 400 g birthweight, or
	— spontaneous abortion (less than 20 weeks' gestational age, or less than 400 g birthweight if gestational age is unknown), or
	— induced abortion (termination of pregnancy before 20 weeks' gestation), or
	— ectopic pregnancy.
Context:	Perinatal statistics:
	The number of previous pregnancies is an important component of the woman's reproductive history. Parity may be a risk factor for adverse maternal and perinatal outcomes. A previous history of stillbirth or spontaneous abortion identifies the mother as high risk for subsequent pregnancies. A previous history of induced abortion may increase the risk of some outcomes in subsequent pregnancies.

Relational and representational attributes

Data type: Numeric   ***Maximum field size:***   2

Representational class: Quantitative value   ***Format:***   NN

Data domain:	Two-digit numeric field representing the number of pregnancies for each of the categories above, or '99' for not stated.

Guide for use:	A pregnancy resulting in multiple births should be counted as one pregnancy.
	In multiple pregnancies with more than one type of outcome, the pregnancies should be recorded in the following order:
	– all live births
	– stillbirth
	– spontaneous abortion
	– induced abortion
	– ectopic pregnancy
	Where the outcome was one stillbirth and one live birth, count as stillbirth.
	If a previous pregnancy was a hydatidiform mole, code as spontaneous or induced abortion (or rarely, ectopic pregnancy), depending on the outcome.

Verification rules:

Collection methods:

Related metadata: Is qualified by the data element Date of completion of last previous pregnancy, version 1.

Is used in conjunction with the data element Date of last previous pregnancy, version 1.

Information model link: NHIM   Physical wellbeing

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:

Primary site of cancer

Identifying and definitional attributes

Knowledge base ID:	**000776**	***Version number:***	**1**
Metadata type:	Data element		

Definition:	The primary site is the site of origin of the tumour, as opposed to the secondary or metastatic sites. It is described by reporting the anatomical position (topography) of the tumour.
Context:	This information is collected for the purpose of: – classifying tumours into clinically-relevant groupings on the basis of both their site of origin and their histological type – monitoring the number of new cases of cancer for planning treatment services – epidemiological studies.

Relational and representational attributes

Data type:	Alphanumeric	***Maximum field size:***	5
Representational class:	Code	***Format:***	ANNNN

Data domain:	Cancer registries: The current version of *International Classification of Diseases for Oncology* (ICDO). Hospitals: The current edition of *International Statistical Classification of Diseases and Related Health Problems*, Tenth Revision, Australian Modification (ICD-10-AM).
Guide for use:	Report the primary site of cancer, if known, for patients who have been diagnosed with a cancer. In ICD-10, primary site is identified using a single four-digit code Cxx.x or Dxx.x. In ICDO, primary site is identified using both the Cxx.x code identifying site and the behaviour code to identify whether the site is the primary site. The behaviour code numbers used in ICD-O are listed below:

0   Benign

1   Uncertain whether benign or malignant

   – borderline malignancy

   – low malignant potential

2   Carcinoma in situ

   – intraepithelial

   – non-infiltrating

   – non-invasive

3   Malignant, primary site

6   Malignant, metastatic site

   – malignant, secondary site

9   Malignant, uncertain whether primary or metastatic site

Verification rules:

Collection methods: Cancer registries use Site codes from the current version of ICDO.

In a hospital setting, primary site of cancer should be recorded on the patient's medical record by the patient's attending clinician or medical practitioner, and coded by the hospital's medical records department.

Hospitals use Diagnosis codes from ICD-10-AM. Valid codes must start with C or D.

In hospital reporting, the diagnosis code for each separate primary site cancer will be reported as a Principal diagnosis or an Additional diagnosis as defined in the current edition of the Australian Coding Standards. In death reporting, the Australian Bureau of Statistics uses ICD-10.

Some ICD-10-AM diagnosis codes, e.g. mesothelioma and Kaposi's sarcoma, are based on morphology and not site alone, and include tumours of these types even where the primary site is unknown.

Related metadata: Is a qualifier of the data element Laterality of primary cancer, version 1.

Information model link: NHIM   Assessment event

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

Administrative attributes

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

Source organisation: World Health Organization.

Source document: *International Statistical Classification of Diseases and Related Health Problems*, Tenth Revision (ICD-10).

International Classification of Diseases for Oncology, Second Edition (ICDO-2).

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:

Principal diagnosis

Identifying and definitional attributes

Knowledgebase ID:	**000136**	*Version number:*	**4**
Metadata type:	Data element		

Definition:	The diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care, an episode of residential care or an attendance at the health care establishment.
Context:	Health services: the principal diagnosis is one of the most valuable health data elements. It is used for epidemiological research, casemix studies and planning purposes.
	Admitted patients:
	The principal diagnosis is a major determinant in the classification of Australian Refined Diagnosis Related Groups and Major Diagnostic Categories.

Relational and representational attributes

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

Data domain:	ICD-10-AM current edition.

Guide for use:	The principal diagnosis must be determined in accordance with the Australian Coding Standards. Each episode of admitted patient care must have a principal diagnosis and may have additional diagnoses. The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status. The first edition of ICD-10-AM, the Australian modification of ICD-10, was published by the National Centre for Classification in Health in 1998 and implemented from July 1998. The second edition was published for use from July 2000 and the third edition for use from July 2002.
	For the National Minimum Data Set for Community Mental Health Care and National Minimum Data Set for Residential Mental Health Care:
	Codes can be used from ICD-10-AM or from The ICD-10-AM *Mental Health Manual: An Integrated Classification and Diagnostic Tool for Community—Based Mental Health Services*, published by the National Centre for Classification in Health in 2002.
Verification rules:	As a minimum requirement the Principal diagnosis code must be a valid code from the current edition of ICD-10-AM.
	For episodes of admitted patient care, some diagnosis codes are too imprecise or inappropriate to be acceptable as a principal diagnosis and will group to 951Z, 955Z and 956Z in the Australian Refined Diagnosis Related Groups, Version 4.
	Diagnosis codes starting with a V, W, X or Y, describing the circumstances that cause an injury, rather than the nature of the injury, cannot be used as principal diagnosis. Diagnosis codes which are morphology codes cannot be used as principal diagnosis.

Collection methods:	A principal diagnosis should be recorded and coded upon separation, for each episode of patient care. The principal diagnosis is derived from and must be substantiated by clinical documentation.
	Admitted patients: where the principal diagnosis is recorded prior to discharge (as in the annual census of public psychiatric hospital patients), it is the current provisional principal diagnosis. Only use the admission diagnosis when no other diagnostic information is available. The current provisional diagnosis may be the same as the admission diagnosis.
	Residents: The principal diagnosis should be recorded and coded upon the end of an episode of residential care (i.e. annually for continuing residential care).
Related metadata:	Supersedes the previous data element Principal diagnosis, version 3.
	Relates to the data element Additional diagnosis, version 5.
	Is an alternative to Bodily location of main injury, version 1.
	Relates to the data element Diagnosis onset type, version 1.
	Relates to the data element Diagnosis related group, version 1.
	Relates to the data element External cause — admitted patient, version 4.
	Relates to the data element External cause — human intent, version 4.
	Relates to the data element External cause — non-admitted patient, version 4.
	Is used in the derivation of Major diagnostic category, version 1.
	Is used as an alternative to Nature of main injury — non-admitted patient, version 1.
	Relates to the data element Procedure, version 5.
Information model link:	NHIM Physical wellbeing

Data set specifications:	*Start date*	*End date*
NMDS — Admitted patient care	01/07/2004	
NMDS — Admitted patient mental health care	01/07/2004	
NMDS — Community 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:	Health Data Standards Committee.		
	National Centre for Classification in Health.		
	National Data Standard for Injury Surveillance Advisory Group.		
Source document:	Current edition of *International Statistical Classification of Diseases and Related Health Problems* — Tenth Revision — Australian Modification. National Centre for Classification in Health, Sydney.		
Registration authority:	National Health Information Group.		

Steward:

Comments:

Principal drug of concern

Identifying and definitional attributes

Knowledgebase ID:	**000443**	*Version number:*	**3**
Metadata type:	Data element		

Definition:	The main drug, as stated by the client, that has led a person to seek treatment from the service.
Context:	Alcohol and other drug treatment services. Required as an indicator of the client's treatment needs.

Relational and representational attributes

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

Data domain:	The Australian Standard Classification of Drugs of Concern (ASCDC). ABS Cat. No. 1248.0 (2000). (Plus 2 supplementary codes: code 0005 'opioid analgesics nfd' and code 0006 'psychostimulants nfd'.)

Guide for use:	The principal drug of concern should be the main drug of concern to the client and is the focus of the client's treatment episode. If the client has been referred into treatment and does not nominate a drug of concern, then the drug involved in the client's referral should be chosen.
	The ASCDC provides a number of supplementary codes that have specific uses and these are detailed within the ASCDC, e.g. 0000 = inadequately described.
	Other supplementary codes that are not already specified in the ASCDC may be used in NMDS's when required. In the AODTS NMDS, two additional supplementary codes have been created which enable a finer level of detail to be captured:

Code 0005   'opioid analgesics not further defined' (nfd) is to be used when it is known that the client's Principal drug of concern is an opioid but the specific opioid used is not known. The existing code 1000 combines opioid analgesics and non-opioid analgesics together into Analgesics nfd and the finer level of detail, although known, is lost.

Code 0006   'psychostimulants nfd' is to be used when it is known that the client's Principal drug of concern is a psychostimulant but not which type. The existing code 3000 combines stimulants and hallucinogens together into Stimulants and hallucinogens nfd and the finer level of detail, although known, is lost.

Psychostimulants refer to the types of drugs that would normally be coded to 3100–3199, 3300–3399 and 3400–3499 categories plus 3903 and 3905.

Verification rules:

Collection methods:	To be collected on commencement of the treatment episode.
	For clients whose treatment episode is related to the alcohol and other drug use of another person, this data element should not be collected.

Related metadata:	Supersedes the previous data element Principal drug of concern, version 2.
	Relates to the data element Method of use for principal drug of concern, version 1.
	Relates to the data element Other drug of concern, version 3.
	Is qualified by the data element Client type—alcohol and other drug treatment services, version 3.
	Relates to the data element Main treatment type for alcohol and other drugs, version 1.
	Relates to the 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		01/07/2004	

Administrative attributes

Admin. status:	CURRENT	*Effective Date:*	14/11/2003
Source organisation:	Intergovernmental Committee on Drugs National Minimum Data Set Working Group.		
Source document:			
Registration authority:	National Health Information Group.		
Steward:			
Comments:			

Procedure

Identifying and definitional attributes

Knowledgebase ID: *000137*   *Version number:*   *5*

Metadata type: Data element

Definition:	A clinical intervention that:
	– is surgical in nature, and/or
	– carries a procedural risk, and/or
	– carries an anaesthetic risk, and/or
	– requires specialised training, and/or
	– requires special facilities or equipment only available in an acute care setting.
Context:	This item gives an indication of the extent to which specialised resources, for example, human resources, theatres and equipment, are used. It also provides an estimate of the numbers of surgical operations performed and the extent to which particular procedures are used to resolve medical problems. It is used for classification of episodes of acute care for admitted patients into Australian refined diagnosis related groups.

Relational and representational attributes

Data type: Numeric   *Maximum field size:*   8

Representational class: Code   *Format:*   NNNNN-NN

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

Guide for use:	Admitted patients: record all procedures undertaken during an episode of care in accordance with the ICD-10-AM Australian Coding Standards.
	The order of codes should be determined using the following hierarchy:
	– procedure performed for treatment of the principal diagnosis
	– procedure performed for the treatment of an additional diagnosis
	– diagnostic/exploratory procedure related to the principal diagnosis
	– diagnostic/exploratory procedure related to an additional diagnosis for the episode of care.
Verification rules:	As a minimum requirement procedure codes must be valid codes from ICD-10-AM procedure codes and validated against the nationally agreed age and sex edits. More extensive edit checking of codes may be utilised within individual hospitals and state and territory information systems.
Collection methods:	Record and code all procedures undertaken during 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. Procedures are derived from and must be substantiated by clinical documentation.

Supersedes previous data element Additional procedures — ICD-10-AM code, version 4.

Supersedes previous data element Additional procedures — ICD-9-CM code, version 3.

Supersedes previous data element Principal procedure — ICD-9-CM code, version 3.

Supersedes the previous data element Principal procedure —ICD-10-AM code, version 4.

Is used in conjunction with the data element Indicator procedure, version 3.

Is qualified by the data element Principal diagnosis, version 4.

Is qualified by the data element Additional diagnosis, version 5.

Relates to the data element Date of procedure, version 1.

Information model link:	NHIM	Service provision event

Data set specifications:	*Start date*	*End date*
NMDS — Admitted patient care	01/07/1999	

Administrative attributes

Admin. status:	CURRENT	*Effective Date:*	01/07/1999

Source organisation:	National Centre for Classification in Health.
	Health Data Standards Committee.

Source document:	Current edition of *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:	The National Centre for Classification in Health advises the Health Data Standards Committee of relevant changes to the ICD-10-AM.

Proficiency in spoken English

Identifying and definitional attributes

Knowledgebase ID: **002023**   *Version number:*   **2**

Metadata type: Data element

Definition:	A person's self-assessed level of ability to speak English.
Context:	This data element identifies those people who may suffer disadvantage in terms of their ability to access services due to lack of ability in the spoken English language. This information can be used to target the provision of services to people whose lack of ability in spoken English is potentially a barrier to gaining access to government programs and services.
	In conjunction with 'Indigenous status', 'Main language other than English spoken at home' and 'Country of birth', this data element forms the minimum core set of cultural and language indicators recommended by the Australian Bureau of Statistics.

Relational and representational attributes

Data type: Numeric   *Maximum field size:*   1

Representational class: Code   *Format:*   N

Data domain:	0	Not applicable (persons under 5 years of age or who speak only English)
	1	Very well
	2	Well
	3	Not well
	4	Not at all
	9	Not stated/ inadequately described

Guide for use:	Code 0	Not applicable, is to be used for people under 5 year of age and people who speak only English.
	Code 9	Not stated/inadequately described, is not to be used 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:	This data element is only intended to be collected if a person has a
	'Main language other than English spoken at home'; and/or
	'First Language spoken' is not English.
	Recommended question:
	How well do you speak English? (tick one)
	1. Very well
	2. Well

3. Not well

4. Not at all

Generally this would be a self-reported question, but in some circumstances (particularly where a person does not speak English well) assistance will be required in answering this question. It is important that the person's self-assessed proficiency in spoken English be recorded wherever possible. This data element does not purport to be a technical assessment of proficiency but is a self-assessment in the four broad categories outlined above.

This data element is not relevant to and should not be collected for persons under the age of 5 years.

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, this standard should be used wherever practically possible.

Related metadata:	Supersedes previous data element Proficiency in spoken English, 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 1999. Standards for Statistics on Cultural and Language Diversity 1999. Cat. no. 1289.0.		
	Reference through: <http://www.abs.gov.au/Ausstats/abs@.nsf/StatsLibrary/>		
	Select: Other ABS Statistical Standards, Standards for Social, Labour and Demographic Variables, Language 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 advises that the most useful information provided by this data element is in the distinction between the two category groups of Very well/Well and Not well/Not at all.		

Reason for cessation of treatment episode for alcohol and other drugs

Identifying and definitional attributes

Knowledgebase ID:	*000423*	*Version number:*	*2*
Metadata type:	Data element		

Definition:	The reason for the client ceasing to receive a treatment episode from an alcohol and other drug treatment service.
Context:	Alcohol and other drug treatment services. Given the levels of attrition within alcohol and other drug treatment programs, it is important to identify the range of different reasons for ceasing treatment with a service.

Relational and representational attributes

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

Data domain:	1	Treatment completed
	2	Change in main treatment type
	3	Change in the delivery setting
	4	Change in the principal drug of concern
	5	Transferred to another service provider
	6	Ceased to participate against advice
	7	Ceased to participate without notice
	8	Ceased to participate involuntary (non-compliance)
	9	Ceased to participate at expiation
	10	Ceased to participate by mutual agreement
	11	Drug court and/or sanctioned by court diversion service
	12	Imprisoned, other than drug court sanctioned
	13	Died
	98	Other
	99	Not stated/inadequately described

Guide for use:	Codes 1 to 12 listed above are set out as follows to enable a clearer picture of which codes are to be used for what purpose:
	Treatment completed as planned
	Code 1 Treatment completed
	Client ceased to participate
	Code 6 Ceased to participate against advice
	Code 7 Ceased to participate without notice
	Code 8 Ceased to participate involuntary (non-compliance)
	Code 9 Ceased to participate at expiation
	Code 11 Drug court and/or sanctioned by court diversion service

Code 12   Imprisoned, other than drug court sanctioned

Treatment not completed (other)

Code 2   Change in main treatment type

Code 3   Change in the delivery setting

Code 4   Change in the principal drug of concern

Code 5   Transferred to another service provider

Treatment ceased by mutual agreement

Code 10   Ceased to participate by mutual agreement

Code 1   Is to be used when all of the immediate goals of the treatment have been completed as planned. Includes situations where the client, after completing this treatment, either does not commence any new treatment, commences a new treatment episode with a different main treatment or principal drug, or is referred to a different service provider for further treatment.

Code 2   A treatment episode will end if, prior to the completion of the existing treatment, there is a change in the Main treatment type for alcohol and other drugs. See also code 10.

Code 3   A treatment episode may end if, prior to the completion of the existing treatment, there is a change in the Treatment delivery setting for alcohol and other drugs. See also code 10 and Guide for use section in Data element 'Treatment episode for alcohol and other drugs'.

Code 4   A treatment episode will end if, prior to the completion of the existing treatment, there is a change in the Principal drug of concern. See also code 10.

Code 5   Includes situations where the service provider is no longer the most appropriate and the client is transferred/referred to another service. For example, transfers could occur for clients between non-residential and residential services or between residential services and a hospital. Excludes situations where the original treatment was completed before the client transferred to a different provider for other treatment (use code 1).

Code 6   Refers to situations where the service provider is aware of the client's intention to stop participating in treatment, and the client ceases despite advice from staff that such action is against the client's best interest.

Code 7   Refers to situations where the client ceased to receive treatment without notifying the service provider of their intention to no longer participate.

Code 8   refers to situations where the client's participation has been ceased by the service provider due to non-compliance with the rules or conditions of the program.

Code 9   Refers to situations where the client has fulfilled their obligation to satisfy expiation requirements (e.g. participate in a treatment program to avoid having a criminal conviction being recorded against them) as part of a police or court diversion scheme and chooses not to continue with further treatment.

Code 10   Refers to situations where the client ceases participation by mutual agreement with the service provider even though the treatment plan has not been completed. This may include situations where the client has moved out of the area. Only to be used when code 2, 3 or 4 is not applicable.

Code 11   Applies to drug court and/or court diversion service clients who are sanctioned back into jail for non-compliance with the program.

Code 12   Applies to clients who are imprisoned for reasons other than code 11.

Verification rules:

Collection methods: To be collected on cessation of a treatment episode.

Related metadata: Supersedes the previous data element Reason for cessation of treatment, version 1.

                               Relates to the data element concept Cessation of treatment episode for alcohol and other drugs, version 2.

                               Relates to the data element Date of cessation of treatment episode for alcohol and other drugs, version 2.

Information model link: NHIM   Exit/leave from a service event

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:

Sex

Identifying and definitional attributes

Knowledgebase ID:	**002024**	*Version number:*	**4**
Metadata type:	Data element		

Definition:	Sex is the biological distinction between male and female. Where there is an inconsistency between anatomical and chromosomal characteristics, sex is based on anatomical characteristics.
Context:	Sex is a core data element in a wide range of social, labour and demographic statistics.

Relational and representational attributes

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

Data domain:	1	Male
	2	Female
	3	Intersex or indeterminate
	9	Not stated/inadequately described

Guide for use:	Code 3 Intersex or indeterminate, refers to a person, who because of a genetic condition, was born with reproductive organs or sex chromosomes that are not exclusively male or female or whose sex has not yet been determined for whatever reason.
Verification rules:	Code 3 should be confirmed if reported for people aged 90 days or greater.
	Diagnosis and procedure codes should be checked against the national ICD-10-AM sex edits, unless the person is undergoing, or has undergone a sex change as detailed in collection methods or has a genetic condition resulting in a conflict between sex and ICD-10-AM code.
Collection methods:	Operationally, sex is the distinction between male and female, as reported by a person or as determined by an interviewer.
	When collecting data on sex by personal interview, asking the sex of the respondent is usually unnecessary and may be inappropriate, or even offensive. It is usually a simple matter to infer the sex of the respondent through observation, or from other cues such as the relationship of the person(s) accompanying the respondent, or first name. The interviewer may ask whether persons not present at the interview are male or female.
	A person's sex may change during their lifetime as a result of procedures known alternatively as Sex change, Gender reassignment, Transsexual surgery, Transgender reassignment or Sexual reassignment. Throughout this process, which may be over a considerable period of time, sex could be recorded as either Male or Female.
	In data collections that use the ICD-10-AM classification, where sex change is the reason for admission, diagnoses should include the appropriate ICD-10-AM code(s) that clearly identify that the person is

undergoing such a process. This code(s) would also be applicable after the person has completed such a process, if they have a procedure involving an organ(s) specific to their previous sex (e.g. where the patient has prostate or ovarian cancer).

Code 3 Intersex or indeterminate, is normally used for babies for whom sex has not been determined for whatever reason; should not generally be used on data collection forms completed by the respondent; and should only be used if the person or respondent volunteers that the person is intersex or where it otherwise becomes clear during the collection process that the individual is neither male nor female.

Code 9 is not to be used 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.

Related metadata:	Supersedes previous data element Sex, version 3.
	Is used in the derivation of Diagnosis related group, 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 — 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:	Australian Bureau of Statistics.		
Source document:	The ABS standards for the collection of Sex 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/Sex.		
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 definition for Intersex in Guide for use is sourced from the ACT Legislation (Gay, Lesbian and Transgender) Amendment Act 2003.

DSS—Diabetes (clinical):

Referring to the National Diabetes Register Statistical profile (December 2000), the sex ratio varied with age. For ages less than 25 years, numbers of males and females were similar. At ages 25–44 years, females strongly outnumbered males, reflecting the effect of gestational diabetes in women from this group. For older age groups (45–74 years), males strongly outnumber females and in the group of 75 and over, the ratio of males to females was reversed, with a substantially lower proportion of males in the population in this age group due to the higher female life expectancy. (AIHW National Mortality Database 1997/98; National Diabetes Register; Statistical Profile, December 2000).

Source of referral to alcohol and other drug treatment service

Identifying and definitional attributes

Knowledgebase ID:	***000444***	*Version number:*	***3***
Metadata type:	Data element		

Definition:	The source from which the person was transferred or referred to the alcohol and other drug treatment service.
Context:	Alcohol and other drug treatment services. Source of referral is important in assisting in the analyses of inter-sectoral patient/client flow and for health care planning.

Relational and representational attributes

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

Data domain:	01	Self
	02	Family member/friend
	03	Medical practitioner
	04	Hospital
	05	Mental health care service
	06	Alcohol and other drug treatment service
	07	Other community/health care service
	08	Correctional service
	09	Police diversion
	10	Court diversion
	98	Other
	99	Not stated/inadequately described

Guide for use:	Code 03	Medical practitioner, includes medical specialists, vocationally registered general practitioners, vocationally registered general practitioner trainees and other primary-care medical practitioners in private practice.
	Code 04	Hospital, includes public and private hospitals, hospitals specialising in dental, ophthalmic aids and other specialised medical or surgical care, satellite units managed and staffed by a hospital, emergency departments of hospitals, and mothercraft hospitals. Excludes psychiatric hospitals, psychiatric units and drug and alcohol units located within or operating from hospitals, and outpatient clinics (see codes 05–07).
	Code 05	Mental health care service, includes both residential and non-residential services. Includes psychiatric hospitals and psychiatric units within and outside of hospitals.

Code 06   Alcohol and other drug treatment service, includes both residential and non-residential services. Includes drug and alcohol units within and outside of hospitals.

Code 07   Other community/health care service, includes outpatient clinics and aged care facilities.

Code 09   Police diversion, this code should be used when a person detained for a minor drug offence is formally referred to treatment by the police in order to divert the offender from the criminal justice pathway.

Code 10   Court diversion, this code refers to the diversion of an offender into drug education, assessment and treatment at the discretion of a magistrate. This may occur at the point of bail or prior to sentencing.

Code 98   Other, includes persons referred under a legislative act (other than Drug Diversion Act) e.g. Mental Health Act.

Verification rules:

Collection methods:

Related metadata: Supersedes previous data element Source of referral to alcohol and other drug treatment service, version 2.

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

Data set specifications:	*Start date*	*End date*
NMDS — Alcohol and other drug treatment services	01/07/2004	

Administrative attributes

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

Source organisation:

Source document:

Registration authority: National Health Information Group.

Steward:

Comments:

Status of the baby

Identifying and definitional attributes

Knowledgebase ID:	**000159**	*Version number:*	**1**
Metadata type:	Data element		

Definition:	Status of the baby at birth.
Context:	Perinatal statistics: essential to analyse outcome of pregnancy.

Relational and representational attributes

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

Data domain:	1	Live birth
	2	Stillbirth (fetal death)
	9	Not stated

Guide for use:	Live birth is the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered liveborn (World Health Organization, 1992 definition).
	Stillbirth is a fetal death prior to the complete expulsion or extraction from its mother of a product of conception of 20 or more completed weeks of gestation or of 400 g or more birthweight; the death is indicated by the fact that after such separation the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. (This is the same as the WHO definition of fetal death, except that there are no limits of gestational age or birthweight for the WHO definition.)
Verification rules:	
Collection methods:	
Related metadata:	Relates to the data element concept Live birth, version 1.
	Relates to the data element concept Stillbirth (fetal death), version 1.
	Is qualified by the data element Apgar score at 1 minute, version 1.
	Is used in conjunction with the data element Resuscitation of baby, version 2.
Information model link:	NHIM Physical wellbeing

Data set specifications:		*Start date*	*End date*
NMDS — Perinatal		01/07/1997	

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:

Stillbirth (fetal death)

Identifying and definitional attributes

Knowledgebase ID:	**000160**	*Version number:*	**1**
Metadata type:	Data element concept		

Definition:	A fetal death prior to the complete expulsion or extraction from its mother of a product of conception of 20 or more completed weeks of gestation or of 400 g or more birthweight; the death is indicated by the fact that after such separation the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.
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 Death event

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:	The World Health Organization definition of live birth, and the legal definition used in Australian states and Territories, do not specify any lower limit for gestational age or birthweight. In practice, liveborn fetuses of less than 20 weeks' gestation are infrequently registered as live births. In analysing data from the perinatal collections, it is recommended that the same criteria of gestational age and birthweight should be used for live births and stillbirths. Births for which gestational age and birthweight have not been recorded (usually occurring outside hospitals) should be included in the perinatal collections if it seems likely		

that the criteria have been met.

Terminations of pregnancy performed at gestational ages of 20 or more weeks should be included in perinatal collections and should be recorded either as stillbirths or, in the unlikely event of showing evidence of life, as live births.

Suburb/town/locality name

Identifying and definitional attributes

Knowledgebase ID:	**002026**	*Version number:*	**2**
Metadata type:	Data element		

Definition:	The full name of the general locality containing the specific address.
Context:	In conjunction with the data element Postcode — Australia, the data element Suburb/town/locality name is included as an alternative means of reporting information about the geographic location of the residence of a client, or an agency/establishment or where an event occurred. The preferred standard for reporting this information is by using a statistical local area (SLA) in conjunction with a state/territory code. However, as some agencies may have difficulty allocating SLA codes to the residential locations of their clients without more computerised assistance than is currently available to them, agencies may be given the option of reporting this information by using Postcode — Australian plus Suburb/town/locality name.
	Suburb/town/locality name may also be a component of a postal address.

Relational and representational attributes

Data type:	Alphabetic	*Maximum field size:*	50
Representational class:	Text	*Format:*	A(50)

Data domain:	Suburb/Town/Locality, which may be a town, city, suburb or commonly used location name such as a large agricultural property or Aboriginal community.

Guide for use:	The Australian Bureau of Statistics has suggested that a maximum field length of 50 characters should be sufficient to record the vast majority of locality names.
	This item may be used to describe the location of person, organisation or event. It can be a component of a street or postal address.
Verification rules:	
Collection methods:	Enter 'Unknown' when the locality name or geographic area for a person or event is not known.
	Enter 'No fixed address' when a person has no fixed address or is homeless.
Related metadata:	Supersedes previous data element Suburb/town/locality, version 1.
	Is used in the derivation of Postal delivery point identifier, version 2.
Information model link:	NHIM Address element

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: Health Data Standards Committee.

National Community Services Data Committee.

Source document: 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 *National Health Data Dictionary* and the *National Community Services Data Dictionary*.

Telephone number

Identifying and definitional attributes

Knowledgebase ID:	**002027**	*Version number:*	**2**
Metadata type:	Data element		

Definition:	Person or organisation contact telephone number.
Context:	Concerned with the use of person identification data. For organisations that create, use or maintain records on people. Organisations should use this standard, where appropriate, for collecting data when registering people. The positive and unique identification of people is a critical event in service delivery, with direct implications for the safety and quality of care delivered by health and community services.

Relational and representational attributes

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

Data domain:	Numbers and spaces only.

Guide for use:	More than one phone number may be recorded as required. Each phone number should have an appropriate 'Telephone number type' code assigned.
	Record the full phone number (including any prefixes) with no punctuation (hyphens or brackets).
Verification rules:	Numbers and spaces only.
Collection methods:	Prefix plus telephone number:
	Record the prefix plus telephone number. The default should be the local prefix with an ability to overtype with a different prefix.
	For example, 08 8226 6000 or 0417 123456.
	Punctuation:
	Do not record punctuation.
	For example, (08) 8226 6000 or 08-8226 6000 would not be correct.
	Unknown:
	Leave the field blank.
Related metadata:	Supersedes previous data element Telephone number, version 1.
	Is qualified by data element Telephone number type, version 2.
Information model link:	NHIM Address element

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: 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 *National Health Data Dictionary* and the *National Community Services Data Dictionary*.

Telephone number type

Identifying and definitional attributes

Knowledgebase ID:	**002028**	*Version number:*	**2**
Metadata type:	Data element		

Definition:	A code representing a type of telephone number.
Context:	Concerned with the use of person identification data. For organisations that create, use or maintain records on people. Organisations should use this standard, where appropriate, for collecting data when registering people. The positive and unique identification of people is a critical event in service delivery, with direct implications for the safety and quality of care delivered by health and community services.

Relational and representational attributes

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

Data domain:	B	Business or work
	H	Home
	M	Personal mobile
	N	Contact number (not own)
	O	Business or work mobile
	T	Temporary

Guide for use:	Where more than one telephone number has been recorded, then each telephone number should have the appropriate Telephone number type code assigned.
Verification rules:	
Collection methods:	
Related metadata:	Supersedes the previous data element Telephone number type, version 1.
Information model link:	NHIM Address element

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:	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 *National Health Data Dictionary* and the *National Community Services Data Dictionary*.

Treatment delivery setting for alcohol and other drugs

Identifying and definitional attributes

Knowledgebase ID:	**000646**	*Version number:*	**2**
Metadata type:	Data element		

Definition:	The main physical setting in which the type of treatment that is the principal focus of their alcohol and other drug treatment episode is actually delivered to a client, irrespective of whether or not this is the same as the usual location of the service provider.
Context:	Alcohol and other drug treatment services. Required to identify the settings in which treatment is occurring, allowing for trends in treatment patterns to be monitored.

Relational and representational attributes

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

Data domain:	1	Non-residential treatment facility
	2	Residential treatment facility
	3	Home
	4	Outreach setting
	8	Other

Guide for use:	Only one code to be selected at the end of the alcohol and other drug treatment episode. Agencies should report the setting in which most of the main type of treatment (as reported in Main treatment type for alcohol and other drugs) was received by the client during the treatment episode.
	Code 1 Non-residential treatment facility, refers to any non-residential centre that provides alcohol and other drug treatment services, including hospital outpatient services and community health centres.
	Code 2 Residential treatment facility, refers to community-based settings in which clients reside either temporarily or long-term in a facility that is not their home or usual place of residence to receive alcohol and other drug treatment. This does not include ambulatory situations, but does include therapeutic community settings.
	Code 3 Home, refers to the client's own home or usual place of residence.
	Code 4 Outreach setting, refers to an outreach environment, excluding a client's home or usual place of residence, where treatment is provided. An outreach environment may be any public or private location that is not covered by codes 1–3. Mobile/outreach alcohol and other drug treatment service providers would usually provide treatment within this setting.

Verification rules:

Collection methods:

Related metadata:　　　　　　Supersedes the previous data element Treatment delivery setting for alcohol and other drugs, version 1.

　　　　　　　　　　　　　　　Related to the data element Main treatment type for alcohol and other drugs, version 1.

Information model link:　　　NHIM　　　　Address element

Data set specifications:	*Start date*	*End date*
NMDS — Alcohol and other drug treatment services	01/07/2004	

Administrative attributes

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

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

Source document:

Registration authority:　　　National Health Information Group.

Steward:

Comments:

Treatment episode for alcohol and other drugs

Identifying and definitional attributes

Knowledgebase ID: **000647**   *Version number:*   *2*

Metadata type: Data element concept

Definition:	The period of contact, with defined dates of commencement and cessation, between a client and a treatment provider or team of providers in which there is no change in the Main treatment type or Principal drug of concern, and there has not been a non-planned absence of contact for greater than three months.
Context:	Alcohol and drug treatment services. This concept is required to provide the basis for a standard approach to recording and monitoring patterns of service utilisation by clients.

Relational and representational attributes

Data type: *Maximum field size:*

Representational class: *Format:*

Data domain:

Guide for use:	A treatment episode must have a defined Date of commencement of treatment episode for alcohol and other drugs and a Date of cessation of treatment episode for alcohol and other drugs.
	A treatment episode can have only one Main treatment type for alcohol and other drugs and only one Principal drug of concern. If the Main treatment or Principal drug changes then the treatment episode is closed and a new treatment episode is opened.
	A treatment episode may also be considered closed (ceased) if there is a change in the treatment delivery setting or the service delivery outlet. Where the change reflects a substantial alteration in the nature of the treatment episode, for instance where an agency operates in more than one treatment setting (or outlet) they may consider that a change from one setting (or outlet), to another necessitates closure of one episode and commencement of a new one.
Verification rules:	
Collection methods:	Is taken as the period starting from the date of commencement of treatment and ending at the date of cessation of treatment episode.
Related metadata:	Supersedes the previous data element Treatment episode for alcohol and other drugs, version 1.
	Relates to the data element Main treatment type for alcohol and other drugs, version 1.
	Relates to the data element Treatment delivery setting for alcohol and other drugs, version 2.
	Relates to the data element Date of commencement of treatment episode for alcohol and other drugs, version 1.

Relates to the data element Date of cessation of treatment episode for a alcohol and other drugs, version 2.

Relates to the data element concept Commencement of treatment episode for alcohol and other drugs, version 2.

Relates to the data element concept Cessation of treatment episode for alcohol and other drugs, version 2.

Information model link: NHIM   Address element

Administrative attributes

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

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

Source document:

Registration authority: National Health Information Group.

Steward:

Comments:

Vascular history

Identifying and definitional attributes

Knowledgebase ID:	**000676**	*Version number:*	**1**
Metadata type:	Data element		

Definition:	Describes the vascular history of the person.
Context:	Public health, health care and clinical settings:
	The vascular history of the patient is important as an element in defining future risk for a cardiovascular event and as a factor in determining best practice management for various cardiovascular risk factor(s).
	It may be used to map vascular conditions, assist in risk stratification and link to best practice management.

Relational and representational attributes

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

Data domain:	01	Myocardial infarction
	02	Unstable angina pectoris
	03	Angina
	04	Heart failure
	05	Atrial fibrillation
	06	Other dysrhythmia or conductive disorder
	07	Rheumatic heart disease
	08	Non-rheumatic valvular heart disease
	09	Left ventricular hypertrophy
	10	Stroke
	11	Transient ischaemic attack
	12	Hypertension
	13	Peripheral vascular disease (includes abdominal aortic aneurism)
	14	Deep vein thrombosis
	15	Other atherosclerotic disease
	16	Carotid stenosis
	17	Vascular renal disease
	18	Vascular retinopathy (hypertensive)
	19	Vascular retinopathy (diabetic)
	97	Other vascular
	98	No vascular history
	99	Unknown/ not stated / not specified

Guide for use:	More than one code can be recorded.

Verification rules:

Collection methods:	Ideally, Vascular history information is derived from and substantiated by clinical documentation.
Related metadata:	Relates to the data element Service contact date, version 1.
	Is used in conjunction with the data element Date of diagnosis, version 1.
Information model link:	NHIM Physical wellbeing

Data set specifications:	*Start date*	*End date*
DSS — Acute coronary syndrome (clinical)	04/06/2004	
DSS — Cardiovascular disease (clinical)	01/01/2003	

Administrative attributes

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

Source organisation:	Cardiovascular Data Working Group.
	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. National Centre for Classification in Health, Sydney.
Registration authority:	National Health Information Group.
Steward:	
Comments:	Further work needs to be undertaken to ensure that the values in the data domain can be mapped to the current version of ICD-10-AM.

Waiting list category

Identifying and definitional attributes

Knowledgebase ID: **000176**   ***Version number:***   **3**

Metadata type: Data element

Definition:	The type of elective hospital care that a patient requires.
Context:	Admitted patients:
	Hospitals maintain waiting lists which may include patients awaiting hospital care other than elective surgery — for example, dental surgery and oncology treatments. This item is necessary to distinguish patients awaiting elective surgery (code 1) from those awaiting other types of elective hospital care (code 2).
	The waiting period for patients awaiting transplant or obstetric procedures is largely independent of system resource factors.

Relational and representational attributes

Data type: Numeric   *Maximum field size:*   1

Representational class: Code   *Format:*   N

Data domain:	1	Elective surgery
	2	Other

Guide for use:	Elective surgery comprises elective care where the procedures required by patients are listed in the surgical operations section of the Medicare Benefits Schedule, with the exclusion of specific procedures frequently done by non-surgical clinicians.
	Elective care is care that, in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least twenty-four hours.
	Patients awaiting the following procedures should be classified as Code 2, Other:

- organ or tissue transplant procedures
- procedures associated with obstetrics (e.g. elective caesarean section, cervical suture)
- cosmetic surgery, i.e. when the procedure will not attract a Medicare rebate
- biopsy of:
  - kidney (needle only)
  - lung (needle only)
  - liver and gall bladder (needle only)
- bronchoscopy (including fibre-optic bronchoscopy)
- peritoneal renal dialysis; haemodialysis
- colonoscopy
- endoscopic retrograde cholangio-pancreatography (ERCP)

- endoscopy of:
  - biliary tract
  - oesophagus
  - small intestine
  - stomach
- endovascular interventional procedures
- gastroscopy
- miscellaneous cardiac procedures
- oesophagoscopy
- panendoscopy (except when involving the bladder)
- proctosigmoidoscopy
- sigmoidoscopy
- anoscopy
- urethroscopy and associated procedures
- dental procedures not attracting a Medicare rebate
- other diagnostic and non-surgical procedures.

These procedure terms are also defined by the current edition of ICD-10-AM *(International Classification of Diseases* — Tenth Revision — Australian Modification, National Centre for Classification in Health, Sydney) codes which are listed under Comments below. This coded list is the recommended, but optional, method for determining whether a patient is classified as requiring elective surgery or other care.

All other elective surgery should be included in waiting list Code 1 — elective surgery.

Verification rules:	
Collection methods:	
Related metadata:	Supersedes previous data element Waiting list category — ICD-9-CM code, version 2.
	Relates to the data element concept Elective care, version 1.
	Is used in conjunction with the data element Patient listing status, version 3.
	Is supplemented by the data element Indicator procedure, version 3.
Information model link:	NHIM Request for/entry into service event

Data set specifications:		***Start date***	***End date***
NMDS — Elective surgery waiting times		01/07/1999	

Administrative attributes

Admin. status:	CURRENT	***Effective Date:***	01/01/1995
Source organisation:	Hospital Access Program Waiting Lists Working Group.		
	Waiting Times Working Group.		
	Health Data Standards Committee.		

Source document:	Current edition of the *International Classification of Diseases* — Tenth Revision — Australian Modification. National Centre for Classification in Health, Sydney.
Registration authority:	National Health Information Group.
Steward:	
Comments:	The table of ICD-10-AM procedure codes was prepared by the National Centre for Classification in Health. Some codes were excluded from the list on the basis that they are usually performed by non-surgeon clinicians. A more extensive and detailed listing of procedure descriptors is under development. This will replace the list in the Guide for use above, to facilitate more readily the identification of the exclusions when the list of codes is not used.

ICD-10-AM CODES FOR THE EXCLUDED PROCEDURES:

Organ or tissue transplant:

90172-00 [555] 90172-01 [555] 90204-00 [659] 90204-01 [659] 90205-00 [660] 90205-01 [660] 13700-00 [801] 13706-08 [802] 13706-00 [802] 13706-06 [802] 13706-07 [802] 13706-09 [802] 13706-10 [802] 30375-21 [817] 90317-00 [954] 90324-00 [981] 36503-00 [1058] 36503-01 [1058] 14203-01 [1906]

Procedures associated with obstetrics:

16511-00 [1274] Obstetric Blocks [1330] to [1345] and [1347]

Biopsy (needle) of:

- – kidney: 36561-00 [1047]
- – lung: 38412-00 [550]
- – liver and gall bladder: 30409-00 [953] 30412-00 [953] 90319-01 [951] 30094-04 [964]

Bronchoscopy:

41889-00 [543] 41892-00 [544] 41904-00 [546] 41764-02 [416] 41895-00 [544] 41764-04 [532] 41892-01 [545] 41901-00 [545] 41898-00 [543] 41898-01 [544] 41889-01 [543] 41849-00 [520] 41764-03 [520] 41855-00 [520]

Peritoneal renal dialysis:

13100-06 [1061] 13100-07 [1061] 13100-08 [1061] 13100-00 [1060]

Endoscopy of biliary tract:

30484-00 [957] 30484-01 [957] 30484-02 [974] 30494-00 [971] 30452-00 [971] 30491-00 [958] 30491-01 [958] 30485-00 [963] 30485-01 [963] 30452-01 [958] 30450-00 [959] 30452-02 [959] 90349-00 [975]

Endoscopy of oesophagus:

30473-03 [850] 30473-04 [861] 41822-00 [861] 30478-11 [856] 41819-00 [862] 30478-10 [852] 30478-13 [861] 41816-00 [850] 41822-00 [861] 41825-00 [852] 30478-12 [856] 41831-00 [862] 30478-12 [856] 30490-00 [853] 30479-00 [856]

Panendoscopy:

30476-03 [874] 32095-00 [891] 30568-00 [893] 30569-00 [894] 30473-05 [1005] 30473-00 [1005] 30473-02 [1005] 30478-00 [1006] 30478-14 [1006] 30478-01 [1007] 30478-02 [1007] 30478-03 [1007] 30478-15 [1007] 30478-16 [1007] 30478-17 [1007] 30478-20 [1007] 30478-21 [1007] 30473-01 [1008] 30478-04 [1008] 30473-06 [1008] 30478-18 [1008]

Endoscopy of large intestine, rectum and anus:

32075-00 [904] 32090-00 [905] 32084-00 [905] 30479-02 [908] 90308-00 [908]
32075-01 [910] 32078-00 [910] 32081-00 [910] 32090-01 [911] 32093-00 [911]
32084-01 [911] 32087-00 [911] 30479-01 [931] 90315-00 [933]

Miscellaneous cardiac:

38603-00 [642] 38600-00 [642] 38256-00 [647] 38256-01 [647] 38256-02 [647]
38278-00 [648] 38278-01 [648] 38284-00 [648] 90202-00 [649] 38470-00 [649]
38473-00 [649] 38281-01 [650] 38281-02 [650] 38281-03 [650] 38281-04 [650]
38281-05 [650] 38281-06 [650] 38281-07 [651] 38281-07 [651] 38281-08 [651]
38281-09 [651] 38281-10 [651] 38281-00 [652] 38278-02 [654] 38456-07 [654]
90203-00 [654] 38284-01 [654] 90219-00 [663] 38281-11 [655] 38281-12 [655]
38212-00 [665] 38209-00 [665] 38200-00 [667] 38203-00 [667] 38206-00 [667]
35324-00 [740] 35315-00 [758] 35315-01 [758]

Endovascular interventional:

35304-01 [670] 35305-00 [670] 35304-00 [670] 35305-01 [670] 35310-00 [671]
35310-01 [671] 35310-03 [671] 35310-04 [671] 35310-02 [671] 35310-05 [671]
34524-00 [694] 13303-00 [694] 34521-01 [694] 32500-01 [722] 32500-00 [722]
13300-01 [738] 13300-02 [738] 13319-00 [738] 13300-00 [738] 13815-00 [738]
13815-01 [738] 34521-02 [738] 34530-04 [738] 90220-00 [738]

Urethroscopy:36800-00 [1090] 36800-01 [1090] 37011-00 [1093] 37008-01
[1093] 37008-00 [1093] 37315-00 [1112] 37315-01 [1116] 37318-01 [1116]
36815-01 [1116] 37854-00 [1116] 35527-00 [1116] 37318-04 [1117]

Dental:

Blocks [450] to [490]

Other diagnostic and non-surgical:

90347-01 [983] 90760-00 [1780] 90767-00 [1780] 13915-00 [1780] 13918-00
[1780] 13921-00 [1780] 13927-00 [1780] 13939-00 [1780] 13942-00 [1780]
90768-00 [1780] Blocks [1820] to 1939], [1940] to [2016]

Appendix A: The Health Data Standards Committee membership

The Health Data Standards Committee membership as at time of publication was:

Organisation	Representative	Address	Contact details
1. Chair	Dr Ching Choi	Head, Health Division Australian Institute of Health & Welfare GPO Box 570 CANBERRA ACT 2601	Ph (02) 6244 1168 Fax (02) 6244 1166 ching.choi@aihw.gov.au
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5. Australian Private Hospital Association representing Private Hospitals	Mr George Neale	Australian Private Hospital Association PO Box 291 Erindale Centre ACT 2903	Ph 0411 104 379 Fax (02) 6291 4466 george.neale@bigpond.com
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7. Australian Government Department of Health and Ageing	Mr Gordon Tomes	Director, HiPIP Data Developments Acute Care Development Branch Acute Care Division Department of Health & Ageing (Australian Government) GPO Box 9848 ACT 2601	Ph (02) 6289 5081 Fax (02) 6289 7630 Gordon.Tomes@health.gov.au
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9. Health Insurance Commission	Ms Julie Henley (retired) Replacement to be advised	Health Insurance Commission PO Box 1001 TUGGERANONG ACT 2901	Ph (02) 6124 6333
10. National Centre for Classification in Health	Ms Sue Walker	Associate Director, National Centre for Classification in Health School of Public Health Queensland University of Technology Victoria Park Road KELVIN GROVE QLD 4059	Ph (07) 3864 5873 Fax (07) 3864 5515 s.walker@qut.edu.au

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11. New South Wales	Ms Patricia Gallagher	Director, Health Informatics Info Management & Support Unit NSW Health Department Locked Mail Bag 961 NORTH SYDNEY NSW 2059	Ph (02) 9391 9164 Fax (02) 9391 9015 pgall@doh.health.gov.nsw.au
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13. Australian Health Insurance Association	Mr Wayne Adams	General Manager (Policy & Research) Australian Health Insurance Association 4 Campion Street DEAKIN ACT 2600	Ph (02) 6285 2977 Fax (02) 6285 2959 wadams@ahia.org.au
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16. Tasmania	Ms Karen Wheeler	Manager, Clinical Data Services Divisional Support Unit Hospitals and Ambulance Services GPO Box 125B HOBART TAS 7001	Ph (03) 6233 4016 Fax (03) 6233 3550 karen.wheeler@dhhs.tas.gov.au
17. Victoria Deputy Chair	Mr Mark Gill	Manager, Health Data Standards and Systems Unit Acute Health Division Department of Human Services GPO Box 4057 MELBOURNE VIC 3001	Ph (03) 9616 7456 Fax (03) 9616 8523 mark.gill@dhs.vic.gov.au
18. Western Australia (interim arrangement)	Ms Gerrie Williams Health Information Policy Consultant in the directorate	Health Information Policy Consultant Health Information Planning Unit Health Department of Western Australia PO Box 8172, Stirling Street PERTH WA 6849	Ph (08) 9222 4228 Fax (08) 9222 4236 gerrie.williams@health.wa.gov.au
19. Clinical informatician (Standards Australia IT14 Health Informatics Committee)	Professor Evelyn Hovenga	Head, School of Information Systems Faculty of Informatics and Communication Central Queensland University Bruce Highway NORTH ROCKHAMPTON QLD 4702	Ph (07) 4930 9839 Fax (07) 4930 9729 e.hovenga@cqu.edu.au
20. Classifications and Terminologies Working Group	Dr David Evans	Medical Superintendent Queen Elizabeth II Jubilee Hospital Private Bag 2 ACACIA RIDGE QLD 4110	Ph (07) 3275 6352 evansd@health.qld.gov.au

Organisation	Representative	Address	Contact details
21. Clinician	Dr Lynette Lee	Senior Lecturer and Staff Specialist in Rehabilitation Medicine Calvary Hospital and St George Developmental Assessment Unit PO Box 261 KOGARAH NSW 1485 (or Suite 13, Level 7 Prince of Wales Private Hospital, Barker St Randwick NSW 2031.)	Ph 0409 909 170 Fax (02) 9386 0992 la.lee@unsw.edu.au
22. Information and Communications Technology Standards Committee	Mr David Rowlands	Director, National InfoStructure Development Department of Health & Ageing c/- Qld Health – Information Services GPO Box 48 BRISBANE QLD 4001	Ph (07)3131 1699 Fax (07)3131 1687 david_rowlands@health.qld.gov.au
23. Consumer	Ms Heather Grain	33 Thurso St East Malvern VIC 3148	Ph (03) 9569 7459 h.grain@latrobe.edu.au
24. Australian Institute of Health and Welfare	Ms Trish Ryan	Head, National Data Development and Standards Unit, AIHW GPO Box 570 CANBERRA ACT 2601	Ph (02) 6244 1054 Fax (02) 6244 1299 trish.ryan@aihw.gov.au

25. Secretariat	Ms Margaret Blood	Australian Institute of Health & Welfare GPO Box 570 CANBERRA ACT 2601	Ph (02) 6244 1123 Fax (02) 6244 1111 margaret.blood@aihw.gov.au

Appendix B: Format for data element definitions

ISO/IEC 11179—based standards

All data element definitions included in the *National Health Data Dictionary* are presented in a format based on ISO/IEC Standard 11179 (1994) *Specification and Standardization of Data Elements* — the international standard for defining data elements issued by the International Organization for Standardization and the International Electrotechnical Commission. Collectively, the format describes a set of attributes for data definitions. The set of attributes for data definitions used in the *National Health Data Dictionary* are described below.

Where an optional attribute is not populated with any information, the attribute is not listed in the data element description.

NHDD information

Admin. status: The operational status (e.g. CURRENT, SUPERSEDED) of the data element or data element concept and the date from which this status is effective. For example, in the NHDD the latest revision of 'Client type – alcohol and other drug treatment services' effective from 1 July 2003 has a 'CURRENT' status, replacing the previous version of this data element operational from 1 July 2002 until 30 June 2003 which now has a 'SUPERSEDED' status. No 'SUPERSEDED' data elements are included in this hard copy publication of the Dictionary. However, all data elements, including 'SUPERSEDED' data elements, are available from the Knowledgebase.

Knowledgebase ID: A six-digit number used to identify the data element on the Knowledgebase (previously known as the NHIK). In the Knowledgebase, this number is preceded by an acronym that identifies the Registration Authority for each data element. The National Health Information Group (NHIG) is the Registration Authority for all data elements included in the Dictionary. The combination of Registration Authority, Knowledgebase (or NHIK) ID and Version Number (see below) uniquely identifies each data element in the Knowledgebase.

Version number: A version number for each data element, beginning with 1 for the initial version of the data element, and 2, 3 etc. for each subsequent revision. This meets the ISO/IEC Standard 11179 requirement for 'identification of a data element specification in a series of evolving data element specifications within a registration authority'. A new Version number is allocated to a data element/data element concept when changes have been made to one or more of the following attributes of the definition:

Metadata name

Definition

Data domain

Identifying and definitional attributes

Metadata item Name: A single or multi-word designation assigned to a data element. This appears in the heading for each unique data definition in the Dictionary.

Metadata type: A data item may be either:

     a.   a data element concept—a concept which can be represented in the form of a data element, described independently of any particular representation. For example, Admission is a process, which does not have any particular representation of its own, except through data elements such as Admission date, Mode of admission, etc.

     b.   a data element—a unit of data for which the definition, identification, representation and permissible values are specified by means of a set of attributes. For example, a hospital 'admission date' is a unit of data for which the definition, identification, representation and permissible values are specified.

     c.   a derived data element—a data element whose values are derived by calculation from the values of other data elements. For example, the data element Length of stay which is derived by calculating the number of days from Admission date to Separation date less any Total leave days;

     d.   a composite data element — a data element whose values represent a grouping of the values of other data elements in a specified order. For example, the data element Establishment identifier is a grouping of the data elements State identifier, Establishment type, Region and Establishment number in that order.

Definition: A statement that expresses the essential nature of an item and its differentiation from all other metadata elements.

Context: A designation or description of the application environment or discipline in which a name is applied or from which it originates. For example, the context for Admission date is Admitted patients, while the context for Capital expenditure— gross is Health expenditure. For the Dictionary this attribute may also include the justification for collecting the items and uses of the information.

Relational and representational attributes

Data type: The type of symbol, character or other designation used to represent a metadata element. Examples include integer, numeric, alphanumeric, etc. For example, the data type for Intended place of birth is a numeric drawn from a data domain, or codeset, in which numeric characters such as 1 = 'hospital', 4 = 'home' are used to denote a data domain value *(see Data domain below).*

Maximum field size: The maximum number of characters required to represent the data element value. For example, a data element value expressed in dollars may require a maximum field size of nine characters (999, 999, 999). Field size does not generally include characters used to mark logical separations of values, e.g. commas, hyphens or slashes.

Representational class: Further defines the Data type.

Format: The Representational layout of characters in the metadata item expressed by a character string representation. Examples include 'DDMMYYYY' for calendar date, 'N' for a one-digit numeric field, and '$$$,$$$,$$$' for expenditure data elements.

Data domain:	The set of representations of permissible instances of the data element, according to Format, Representational class, Data type and Maximum field size specified in the corresponding attributes. The set can be specified by name (including an existing classification/code scheme such as ICD-10-AM), by reference to a source (such as the *ABS Directory of Concepts and Standards for Social, Labour and Demographic Statistics*, 1995), or by enumeration of the representation of the instances (for example, for Compensable status values are 1 = 'Compensable' and 2 = 'Non-compensable').
Guide for use (optional):	Additional comments or advice on the interpretation or application of the attribute 'Data domain' (this attribute has no direct counterpart in the ISO/IEC Standard 11179 but has been included to assist in clarification of issues relating to the classification of data elements). Includes any formulae for derived data elements.
Verification rules (optional):	The rules and/or instructions applied for validating and/or verifying data elements occurring in actual communication and/or databases, in addition to the formal screening based on the requirements laid down in the basic attributes.
Collection methods (optional):	Comments and advice concerning the actual capture of data for the particular data element, including guidelines on the design of questions for use in collecting information, and treatment of 'not stated' or non-response (this attribute is not specified in the ISO/IEC Standard 11179 but has been added to cover important issues about the actual collection of data).
Related data (optional):	A list of all metadata items that are significantly related to this metadata item, including the type of this relationship. Examples include: 'has been superseded by the data element…', 'is calculated using the data element…', and 'supplements the data element…'.
Information model link:	The name of the model entity, e.g. NHIM (National Health Information Model).
Indicator framework link:	The name of the indicator framework entity (only used for performance indicators — left blank for all other data items), e.g. NHPC (National Health Performance Committee).
Data set specifications: (optional):	The name of any national minimum data set established under the auspice of the National Health Information Agreement (NHIA) or any data set specification, which includes this particular metadata item. The date of first effect and date of last effect (if applicable) is also included.

Administrative attributes

Admin. status:	The status of the data item. Examples include, 'CURRENT' and 'SUPERSEDED'.
Source organisation:	The organisation or group responsible for the creation and ongoing maintenance of the data item (this attribute is not specified in the ISO/IEC Standard 11179 but has been added for completeness).
Source document (optional):	A full bibliography of any documents that are reference sources.
Registration authority:	Agency with the authority to register standards.
Steward:	Agency with the responsibility for the content of the metadata item.
Comments (optional):	Any additional information that adds extra understanding to the metadata item.

Appendix C: Data elements and data element concepts included in National Minimum Data Sets

Metadata item	Data element concept	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Community mental health care	Community mental health establishments	Elective surgery waiting times	Health labour force	Injury surveillance	Non-admitted patient Emergency Dept. care	Perinatal	Public hospital establishments	Residential mental health care
Activity when injured, version 3		✓								✓				
Actual place of birth, version 2												✓		
Acute care episode for admitted patients, version 1	✓	✓	✓											
Additional diagnosis, version 5		✓	✓	✓										✓
Administrative expenses, version 1							✓						✓	
Admission, version 3	✓	✓	✓	✓										
Admission date, version 4		✓	✓	✓										
Admitted patient, version 3	✓	✓	✓	✓						✓				
Admitted patient election status, version 1		✓												
Area of usual residence, version 3		✓	✓	✓		✓					✓			✓
Australian state/territory identifier, version 4		✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓
Birth order, version 1												✓		
Birth plurality, version 1												✓		
Birthweight, version 1	✓											✓		
Bodily location of main injury, version 1										✓				
Capital expenditure — gross (accrual accounting), version 2													✓	
Capital expenditure — net (accrual accounting), version 2													✓	
Category reassignment date, version 2								✓						

Metadata item	Data element concept	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Community mental health care	Community mental health establishments	Elective surgery waiting times	Health labour force	Injury surveillance	Non-admitted patient Emergency Dept. care	Perinatal	Public hospital establishments	Residential mental health care
Care type, version 4		✓	✓	✓										
Census date, version 2								✓						
Cessation of treatment episode for alcohol and other drugs, version 2	✓				✓									
Classification of health labour force job, version 1									✓					
Client type — alcohol and other drug treatment service, version 2					✓									
Clinical review, version 1	✓							✓						
Clinical urgency, version 2								✓						
Commencement of treatment episode for alcohol and other drugs, version 2	✓				✓									
Compensable status, version 3											✓			
Country of birth, version 4		✓	✓	✓	✓	✓					✓	✓		✓
Date of birth, version 5		✓	✓	✓	✓	✓			✓		✓	✓		✓
Date of cessation of treatment episode for alcohol and other drugs, version 2					✓									
Date of commencement of treatment episode for alcohol and other drugs, version 1					✓									
Date patient presents, version 1											✓			
Department of Veterans' Affairs patient, version 1											✓			
Depreciation, version 1							✓						✓	
Diagnosis, version 2	✓	✓		✓		✓								✓
Diagnosis related group, version 1		✓	✓											
Domestic services, version 1							✓						✓	
Drug supplies, version 1							✓						✓	
Elective care, version 1	✓							✓						
Elective surgery, version 1	✓							✓						

Metadata item	Data element concept	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Community mental health care	Community mental health establishments	Elective surgery waiting times	Health labour force	Injury surveillance	Non-admitted patient Emergency Dept. care	Perinatal	Public hospital establishments	Residential mental health care
Emergency department arrival mode — transport, version 1											✓			
Emergency department departure status, version 2											✓			
Emergency department waiting time to service delivery, version 1											✓			
Emergency department — public hospital, version 1	✓										✓			
Employment status — acute hospital and private psychiatric hospital admissions, version 2			✓											
Employment status—public psychiatric hospital admissions, version 2			✓											
Episode of admitted patient care, version 2	✓	✓	✓	✓										
Episode of residential care, version 1	✓													✓
Episode of residential care end, version 1	✓													✓
Episode of residential care end date, version 1														✓
Episode of residential care end mode, version 1														✓
Episode of residential care start, version 1	✓													✓
Episode of residential care start date, version 1														✓
Episode of residential care start mode, version 1														✓
Establishment identifier, version 4			✓	✓	✓	✓	✓	✓			✓	✓	✓	✓
Establishment number, version 4		✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓
Establishment sector, version 4		✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓
Establishment type, version 1													✓	
Extended wait patient, version 1								✓						
External cause — admitted patient, version 4		✓								✓				
External cause — human intent, version 4										✓				
First day of last menstrual period, version 1												✓		

Metadata item	Data element concept	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Community mental health care	Community mental health establishments	Elective surgery waiting times	Health labour force	Injury surveillance	Non-admitted patient Emergency Dept. care	Perinatal	Public hospital establishments	Residential mental health care
Food supplies, version 1							✓						✓	
Full-time equivalent staff, version 2							✓						✓	
Funding source for hospital patient, version 1		✓		✓										
Geographical location of establishment, version 2					✓	✓							✓	
Gestational age, version 1												✓		
Gestational age, version 1	✓											✓		
Group sessions, version 1													✓	
Health labour force, version 1	✓								✓					
Hospital, version 1	✓	✓	✓	✓									✓	
Hospital boarder, version 1	✓	✓											✓	
Hospital census, version 1	✓							✓						
Hospital insurance status, version 3		✓												
Hospital-in-the-home care, version 1	✓	✓		✓										
Hospital waiting list, version 1	✓							✓						
Hours on-call (not worked) by medical practitioner, version 2									✓					
Hours worked by health professional, version 2									✓					
Hours worked by medical practitioner in direct patient care, version 2									✓					
Indicator procedure, version 3								✓						
Indigenous status, version 5		✓	✓	✓	✓	✓					✓	✓		✓
Indirect health care expenditure, version 1													✓	
Individual/group session, version 1													✓	
Infant weight, neonate, stillborn, version 3		✓										✓		
Injecting drug use, version 1					✓									

Metadata item	Data element concept	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Community mental health care	Community mental health establishments	Elective surgery waiting times	Health labour force	Injury surveillance	Non-admitted patient Emergency Dept. care	Perinatal	Public hospital establishments	Residential mental health care
Intended length of hospital stay, version 2		✓												
Interest payments, version 1							✓						✓	
Inter-hospital contracted patient, version 2		✓												
Leave days from residential care, version 1														✓
Length of non-admitted patient emergency department service episode, version 1											✓			
Listing date for care, version 4								✓						
Live birth, version 1	✓	✓										✓		
Main treatment type for alcohol and other drugs, version 1					✓									
Major diagnostic category, version 1		✓	✓											
Marital status, version 4			✓			✓								✓
Medical and surgical supplies, version 1							✓						✓	
Medicare eligibility status, version 1		✓												
Mental health legal status, version 5		✓	✓			✓								✓
Method of birth, version 1												✓		
Method of use for principal drug of concern, version 1					✓									
Mode of admission, version 4		✓		✓										
Mode of separation, version 3		✓	✓	✓										
Narrative description of injury event, version 1										✓				
Nature of main injury—non-admitted patient, version 1										✓				
Neonatal death, version 1	✓											✓		
Neonate, version 1	✓	✓										✓		
Newborn qualification status, version 2	✓	✓												
Non-admitted patient, version 1	✓									✓			✓	

Metadata item	Data element concept	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Community mental health care	Community mental health establishments	Elective surgery waiting times	Health labour force	Injury surveillance	Non-admitted patient Emergency Dept. care	Perinatal	Public hospital establishments	Residential mental health care
Non-admitted patient emergency department service episode, version 1											✓			
Non-elective care, version 1	✓							✓						
Non-salary operating costs, version 1							✓							
Number of available beds for admitted patients, version 2							✓						✓	
Number of days of hospital-in-the-home care, version 1		✓		✓										
Number of leave periods, version 3		✓												
Number of qualified days for newborns, version 2		✓												
Occasions of service, version 1													✓	
Onset of labour, version 1												✓		
Organ procurement — posthumous, version 1	✓													
Other drug of concern, version 3					✓									
Other recurrent expenditure, version 1							✓						✓	
Other revenues, version 1													✓	
Other treatment type for alcohol and other drugs, version 1					✓									
Overdue patient, version 3								✓						
Overnight-stay patient, version 3	✓												✓	
Patient, version 1	✓	✓	✓	✓			✓						✓	
Patient listing status, version 3								✓						
Patient presentation at emergency department, version 1	✓										✓			
Patient revenue, version 1													✓	
Patient transport, version 1							✓						✓	
Payments to visiting medical officers, version 1							✓						✓	
Perinatal period, version 1	✓											✓		

Metadata item	Data element concept	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Community mental health care	Community mental health establishments	Elective surgery waiting times	Health labour force	Injury surveillance	Non-admitted patient Emergency Dept. care	Perinatal	Public hospital establishments	Residential mental health care
Person identifier, version 2		✓	✓	✓	✓	✓					✓	✓		✓
Place of occurrence of external cause of injury, version 6		✓								✓				
Preferred language, version 2					✓									
Previous specialised treatment, version 3			✓	✓										
Principal area of clinical practice, version 1									✓					
Principal diagnosis, version 4		✓	✓	✓		✓								✓
Principal drug of concern, version 3					✓									
Principal role of health professional, version 1									✓					
Procedure, version 5		✓												
Profession labour force status of health professional, version 1									✓					
Reason for cessation of treatment episode for alcohol and other drugs, version 2					✓									
Reason for removal from elective surgery waiting list, version 4								✓						
Recoveries, version 1													✓	
Referral from specialised mental health residential care, version 1														✓
Referral to further care (psychiatric patients), version 1			✓											
Region code, version 2		✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓
Removal date, version 1								✓						
Repairs and maintenance, version 1							✓						✓	
Resident, version 1	✓													✓
Residential mental health service, version 1	✓													✓
Residential stay, version 1	✓													✓
Residential stay start date, version 1														✓

Metadata item	Data element concept	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treat-ment services	Comm-unity mental health care	Comm-unity mental health establi-shments	Elective surgery waiting times	Health labour force	Injury surveil-lance	Non-admitted patient Emergency Dept. care	Perinatal	Public hospital establi-shments	Residential mental health care
Salaries and wages, version 1							✓						✓	
Same-day patient, version 1	✓	✓											✓	
Separation, version 3	✓	✓	✓	✓			✓						✓	
Separation date, version 5		✓	✓	✓								✓		
Separations, version 2							✓							
Service contact, version 1	✓					✓								
Service contact date, version 1						✓								
Service delivery outlet, version 1					✓									
Sex, version 4		✓	✓	✓	✓	✓					✓	✓		✓
Source of referral to alcohol and other drug treatment service, version 1					✓									
Source of referral to public psychiatric hospital, version 3		✓	✓											
Specialised mental health service, version 1	✓						✓							✓
Specialised mental health service setting, version 1							✓							
Specialised service indicators, version 1													✓	
State/territory of birth, version 1														
Status of the baby, version 1												✓		
Stillbirth (fetal death), version 2	✓											✓		
Superannuation employer contributions (including funding basis), version 1							✓						✓	
Surgical specialty, version 1								✓						
Teaching status, version 1													✓	
Time of triage, version 1														
Time patient presents, version 1											✓			
Total hours worked by medical practitioner, version 2									✓					

Metadata item	Data element concept	Admitted patient care	Admitted patient mental health care	Admitted patient palliative care	Alcohol and other drug treatment services	Community mental health care	Community mental health establishments	Elective surgery waiting times	Health labour force	Injury surveillance	Non-admitted patient Emergency Dept. care	Perinatal	Public hospital establishments	Residential mental health care
Total leave days, version 3		✓	✓											
Total psychiatric care days, version 2		✓	✓											
Treatment delivery setting for alcohol and other drugs, version 2					✓									
Treatment episode for alcohol and other drugs, version 2	✓				✓									
Triage category, version 1											✓			
Type and sector of employment establishment, version 1									✓					
Type of accommodation, version 2			✓											
Type of non-admitted patient care, version 1													✓	
Type of non-admitted patient care (public psychiatric, alcohol and drug), version 1													✓	
Type of usual accommodation, version 1			✓											
Type of visit to emergency department, version 2											✓			
Urgency of admission, version 1		✓												
Waiting list category, version 3								✓						
Waiting time at a census date, version 1								✓						
Waiting time at removal from elective surgery waiting list, version 2								✓						

National Health Data Dictionary Feedback Form

By Post		By facsimile
Secretariat Health Data Standards Committee GPO Box 570, Canberra ACT 2601		(02) 6244 1111

Or use the 'Kb Feedback' link on 'The Knowledgebase' page on the AIHW website:

<http://www.aihw.gov.au/knowledgebase/index.html >

1. Does the Data Dictionary in this form cater to your needs in relation to data development?

☐ YES ☐ NO

Please comment _____

_____

2. Is the layout of this book easy to follow?

☐ YES ☐ NO

Please comment _____

_____

3. Overall, did you find the Data Dictionary

☐ Very useful ☐ Useful ☐ Adequate ☐ Not useful ☐ a waste of paper

4. Do you have any suggestions for improving the Data Dictionary? _____

_____

_____

_____

5. In what capacity are you interested in the Data Dictionary?

☐ Data entry ☐ Clinical care/research

☐ Program Management ☐ Database development/design

☐ Policy development ☐ Service provision

☐ Other_____

6. Do you work in a:

☐ Commonwealth government department ☐ Service delivery organisation

☐ State/territory government department ☐ Other_____

7. Did you know that the Dictionary is also available on the AIHW website?

☐ YES ☐ NO

Please comment_____

8. Would you be happy for us to contact you if we wish to follow-up on your response?

☐ YES ☐ NO

Name: _____

Organisation: _____

Email: _____

Phone: ( ) _____ fax: ( ) _____