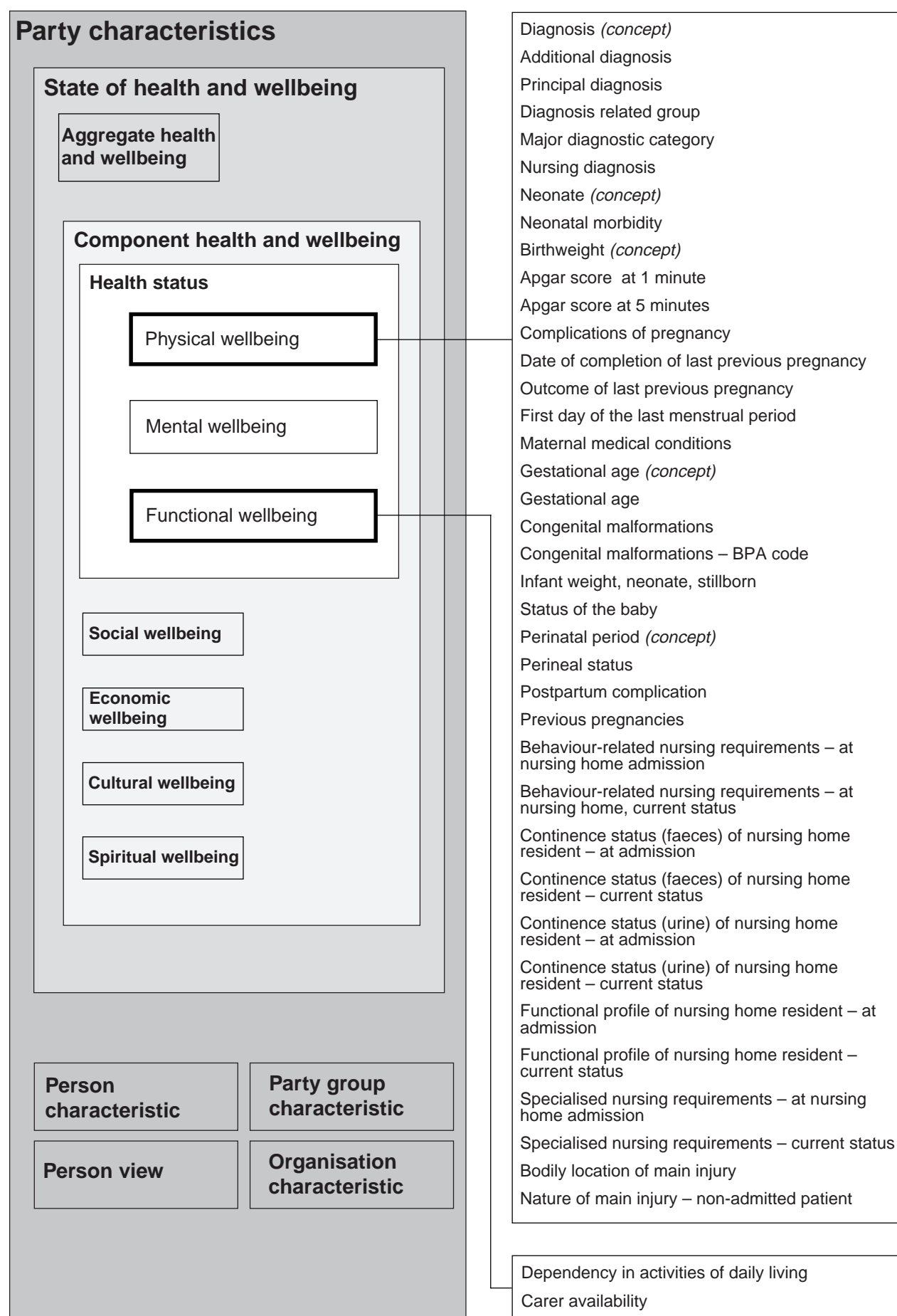


National Health Information Model entities



Diagnosis

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000398 *Version number:* 1

Data element 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.

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

Datatype: *Representational form:*

Field size: *Min.* *Max.* *Representational layout:*

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data: relates to the data element Complications of pregnancy, version 2
 relates to the data element Maternal medical conditions, version 2
 relates to the data element External cause – admitted patient, version 4
 relates to the data element Principal diagnosis, version 3
 relates to the data element Complication of labour and delivery, version 2
 relates to the data element Postpartum complication, version 2
 relates to the data element Neonatal morbidity, version 2
 relates to the data element Congenital malformations, version 2
 relates to the data element Additional diagnosis, version 4

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Comments: Classification systems which enable the allocation of a code to the diagnostic information:
 International Statistical Classification of Diseases and Related Health Problems – Tenth Revision – Australian Modification (1998) (ICD-10-AM)

Diagnosis (*continued*)

Comments (cont'd): British Paediatric Association Classification of Diseases (1979)
North America Nursing Diagnosis Association (NANDA)
International Classification of Primary Care (1987)
International Classification of Impairments, Disabilities and Handicaps (1980)
International Classification of Impairments, Disabilities and Handicaps Beta/1
draft revised classification (1997).

Additional diagnosis

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000005 *Version number:* 4

Data element type: DATA ELEMENT

Definition: A condition or complaint either coexisting with the principal diagnosis or arising during the episode of care or attendance at a health care facility.

Context: Institutional health care: 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.

Relational and representational attributes

Datatype: Alphanumeric *Representational form:* CODE

Field size: *Min.* 3 *Max.* 6 *Representational layout:* ANN.NN

Data domain: ICD-10-AM – disease codes

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.

The first edition of ICD-10-AM, the Australian modification of ICD-10, was published by the National Centre for Classification in Health and implemented from July 1998. New South Wales, Victoria, the Australian Capital Territory and the Northern Territory implemented ICD-10-AM from 1 July 1998. Other States will implement this classification from 1 July 1999.

Verification rules:

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

Related data: supersedes previous data element Additional diagnosis – ICD-9-CM code, version 3
is used in the derivation of Diagnosis related group, version 1
supplements the data element Principal diagnosis, version 3

Additional diagnosis (*continued*)

Administrative attributes

Source document: International Statistical Classification of Diseases and Related Health Problems – Tenth Revision – Australian Modification (1998); National Centre for Classification in Health, Sydney.

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

National minimum data sets:

Institutional health care from 1/07/89 to

Institutional mental health care from 1/07/97 to

Community mental health care from 1/07/2000 to

Palliative care from 1/07/2000 to

Comments: Additional diagnoses are significant for the allocation of Australian Refined Diagnosis Related Groups. The allocation of patients to major problem or complication and co-morbidity Diagnosis Related Groups is made on the basis of the presence of certain specified Additional diagnoses. Additional diagnoses should be recorded when relevant to the patient's episode of care and not restricted by the number of fields on the morbidity form or computer screen.

External cause codes, although not diagnosis or condition codes, should be sequenced together with the additional diagnoses codes so that meaning is given to the data for use in injury surveillance and other monitoring activities.

Principal diagnosis

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000136 *Version number:* 3

Data element type: DATA ELEMENT

Definition: The diagnosis established after study to be chiefly responsible for occasioning the patient's episode of care in hospital (or attendance at the health care facility).

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

Datatype: Alphanumeric *Representational form:* CODE

Field size: *Min.* 3 *Max.* 6 *Representational layout:* ANN.NN

Data domain: ICD-10-AM

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 will be published for use from July 2000.

Verification rules: As a minimum requirement the Principal diagnosis code must be a valid code from ICD-10-AM.

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. A list of these diagnosis codes is available from the Acute and Coordinated Care Branch, Health Services Division, Department of Health and Aged Care.

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.

Principal diagnosis (*continued*)

Collection methods (cont'd): Admitted patients: where the principal diagnosis is recorded prior to discharge (as in the annual census of public psychiatric hospital inpatients), 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.

Related data: supersedes previous data element Principal diagnosis – ICD-9-CM code, version 2
relates to the data element Diagnosis related group, version 1
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
is an alternative to Bodily location of main injury, version 1
relates to the data element External cause – human intent, version 4
relates to the data element External cause – admitted patient, version 4
relates to the data element Additional diagnosis, version 4
relates to the data element External cause – non-admitted patient, version 4
relates to the data element Procedure, version 5

Administrative attributes

Source document: International Statistical Classification of Diseases and Related Health Problems – Tenth Revision – Australian Modification (1998)
National Centre for Classification in Health, Sydney

Source organisation: National Health Data Committee, National Centre for Classification in Health and National Data Standard for Injury Surveillance Advisory Group

National minimum data sets:

Institutional health care	from 1/07/89 to
Institutional mental health care	from 1/07/97 to
Community mental health care	from 1/07/2000 to
Palliative care	from 1/07/2000 to

Comments: The National Centre for Classification in Health advises the National Health Data Committee on relevant changes to the ICD-10-AM. New South Wales, Victoria, the Australian Capital Territory and the Northern Territory implemented ICD-10-AM from 1 July 1998. Other States implemented this classification from 1 July 1999.

Diagnosis related group

Admin. status: CURRENT 1/07/93

Identifying and definitional attributes

Knowledgebase ID: 000042 *Version number:* 1

Data element type: DATA ELEMENT

Definition: A patient classification scheme which provides a means of relating the number and types of patients treated in a hospital to the resources required by the hospital.

Context: Institutional health care: the development of Australian Refined Diagnosis Related Groups has created a descriptive framework for studying hospitalisation. Diagnosis Related Groups provide a summary of the varied reasons for hospitalisation and the complexity of cases a hospital treats. Moreover, as a framework for describing the products of a hospital (that is, patients receiving services), they allow meaningful comparisons of hospitals' efficiency and effectiveness under alternative systems of health care provision.

Relational and representational attributes

Datatype: Alphanumeric *Representational form:* CODE

Field size: *Min.* 4 *Max.* 4 *Representational layout:* ANNA

Data domain: Australian Refined Diagnosis Related Groups, Commonwealth of Australia. Version effective from 1 July each year.

Guide for use:

Verification rules:

Collection methods:

Related data:

- is derived from Sex, version 2
- is derived from Date of birth, version 2
- is derived from Mode of separation, version 2
- is derived from Intended length of hospital stay, version 1
- is derived from Infant weight, neonate, stillborn, version 3
- is derived from Principal diagnosis, version 3
- is derived from Additional diagnosis, version 4
- is derived from Procedure, version 5
- is derived from Separation date, version 5
- is derived from Admission date, version 4

Administrative attributes

Source document:

Source organisation: National Health Data Committee, National Centre for Classification in Health

Diagnosis related group (*continued*)

National minimum data sets:

Institutional health care from 1/07/89 to

Institutional mental health care from 1/07/97 to

Comments: The Australian Refined Diagnosis Related Group is derived from a range of data collected on admitted patients, including diagnosis and procedure information, classified using ICD-10-AM. The data elements required are described in Related data elements.

Major diagnostic category

Admin. status: CURRENT 1/07/93

Identifying and definitional attributes

Knowledgebase ID: 000088 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Major Diagnostic Categories are 23 mutually exclusive categories into which all possible principal diagnoses fall. The diagnoses in each category correspond to a single body system or aetiology, broadly reflecting the speciality providing care. Each category is partitioned according to whether or not a surgical procedure was performed. This preliminary partitioning into Major Diagnostic Categories occurs before a Diagnosis Related Group is assigned.

The Australian Refined Diagnosis Related Groups departs from the use of principal diagnosis as the initial variable in the assignment of some groups. A hierarchy of all exceptions to the principal diagnosis-based assignment to a Major Diagnostic Category has been created. As a consequence, certain Australian Refined Diagnosis Related Groups are not unique to a Major Diagnostic Category. This requires both a Major Diagnostic Category and an Australian Refined Diagnosis Related Group to be generated per patient.

Context: Institutional health care: the generation of a Major Diagnostic Category to accompany each Australian Refined Diagnosis Related Group is a requirement of the latter as Diagnosis Related Groups are not unique.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 2 *Max.* 2 *Representational layout:* NN

Data domain: Australian Refined Diagnosis Related Groups

Guide for use: Version effective 1 July each year

Verification rules:

Collection methods:

Related data: is derived from Date of birth, version 2
is derived from Admission date, version 4
is used in the derivation of Diagnosis related group, version 1
is derived from Infant weight, neonate, stillborn, version 3
is derived from Principal diagnosis, version 3
is derived from Additional diagnosis, version 4

Administrative attributes

Source document:

Source organisation: Department of Health and Aged Care, Acute and Co-ordinated Care Branch

Major diagnostic category (*continued*)

National minimum data sets:

Institutional health care from 1/07/89 to

Institutional mental health care from 1/07/97 to

Comments:

This data item has been created to reflect the development of Australian Refined Diagnosis Related Groups (as defined in the data element Diagnosis related group) by the Acute and Co-ordinated Care Branch, Commonwealth Department of Health and Aged Care. Due to the modifications in the Diagnosis Related Group logic for the Australian Refined Diagnosis Related Groups, it is necessary to generate the Major Diagnostic Category to accompany each Diagnosis Related Group. The construction of the pre-Major Diagnostic Category logic means Diagnosis Related Groups are no longer unique. Certain pre-Major Diagnostic Category Diagnosis Related Groups may occur in more than one of the 23 Major Diagnostic Categories. For example, liver transplant DRG 005, may occur in any of the Major Diagnostic Categories according to the principal diagnosis. AR-DRGs 950-954 (excluding AR-DRG 952 in most cases) also require the allocation of a Major Diagnostic Category according to the principal diagnosis.

Nursing diagnosis

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000110 *Version number:* 2

Data element type: DATA ELEMENT

Definition: Nursing diagnosis is a clinical judgement about individual, family or community responses to actual or potential health problems/life processes. Nursing diagnoses provide the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable.

Context: Enables analysis of information by diagnostic variables especially in relation to the development of outcome information, Goal of care and Nursing intervention. Nursing diagnosis and the data element Nursing intervention have shown to be more predictive of resource use than client's functional status or medical diagnosis.

Relational and representational attributes

Datatype: Alphanumeric *Representational form:* CODE

Field size: *Min.* 3 *Max.* 11 *Representational layout:* N.N.N.N.N.N

Data domain: The North American Nursing Diagnosis Association (NANDA) Taxonomy, 1997-1998

Guide for use: Up to seven nursing diagnoses may be nominated, according to the following:

1. Nursing diagnosis most related to the principal reason for admission (one only)
- 2-6. Other nursing diagnoses of relevance to the current episode.

The NANDA codes should be used in conjunction with a nursing diagnosis text. The NANDA coding structure is a standard format for reporting nursing diagnosis. It is not intended in any way to change or intrude upon nursing practice, provided the information available can transpose to the NANDA codes for the Community Nursing Minimum Data Set – Australia (CNMDSA).

Verification rules:

Collection methods: In considering how nursing diagnosis could be implemented, agencies may opt to introduce systems transparent to the clinician if there is confidence that a direct and reliable transfer to NANDA codes can be made from information already in place.

Agencies implementing new information systems should consider the extent to which these can facilitate practice and at the same time lighten the burden of documentation. Direct incorporation of the codeset or automated mapping to it when the information is at a more detailed level are equally valid and viable options.

Nursing diagnosis (*continued*)

Related data: supersedes previous data element Nursing diagnosis, version 1
 relates to the data element Nursing interventions, version 2
 relates to the data element Goal of care, version 2

Administrative attributes

Source document: NANDA Nursing Diagnoses: Definitions and Classification 1997-1998. (1997)
 North American Nursing Diagnosis Association.

Source organisation: Australian Council of Community Nursing Services

National minimum data sets:

Comments: The CNMDSA Steering Committee considered information from users of the data in relation to Nursing diagnosis. Many users have found the taxonomy wanting in its ability to describe the full range of persons and conditions seen by community nurses in the Australian setting. In the absence of an alternative taxonomy with wide acceptance, the CNMDSA Steering Committee has decided to retain NANDA. The University of Iowa has a written agreement with NANDA to expand the relevance of NANDA. The Australian Council of Community Nursing Services (ACCNS) has sought collaboration with a US project at the University of Iowa which is seeking to refine, extend, validate and classify the NANDA taxonomy.

Neonate

Admin. status: CURRENT 1/07/95

Identifying and definitional attributes

Knowledgebase ID: 000103 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

Definition: A live birth who is less than 28 days old.

Context: Perinatal

Relational and representational attributes

Datatype: *Representational form:*

Field size: *Min.* *Max.* *Representational layout:*

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data:

Administrative attributes

Source document: International Classification of Diseases and Related Health Problems, 10th Revision, WHO, 1992

Source organisation: National Health Data Committee, National Perinatal Data Development Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Perinatal from 1/07/97 to

Comments: The neonatal period is exactly four weeks or 28 completed days, commencing on the date of birth (day 0) and ending on the completion of day 27. For example, a baby born on 1 October remains a neonate until completion of the four weeks on 28 October and is no longer a neonate on 29 October.

Neonatal morbidity

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000102 *Version number:* 2

Data element 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

Datatype: Alphanumeric *Representational form:* CODE

Field size: *Min.* 3 *Max.* 6 *Representational layout:* ANN.NN

Data domain: ICD-10-AM

Guide for use: There is no arbitrary limit on the number of conditions specified.
New South Wales, Australian Capital Territory, Victoria and the Northern Territory implemented ICD-10-AM from 1 July 1998. Other States will implement ICD-10-AM from 1 July 1999.

Verification rules: Conditions should be coded within chapter of Volume 1, ICD-10-AM

Collection methods:

Related data: supersedes previous data element Neonatal morbidity – ICD-9-CM code, version 1
is used in conjunction with Congenital malformations – BPA code, version 1
is used in conjunction with Congenital malformations, version 2

Administrative attributes

Source document: International Statistical Classification of Diseases and Related health Problems – 10th Revision, Australian Modification (1998) National Centre for Classification in Health, Sydney.

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Comments:

Birthweight

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000021 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

Definition: The first weight of the foetus 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

Datatype: *Representational form:*

Field size: *Min.* *Max.* *Representational layout:*

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data:

Administrative attributes

Source document: International Classification of Diseases and Related Health Problems, 10th Revision, WHO, 1992

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Perinatal from 1/07/97 to

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.

Apgar score at 1 minute

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000344 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Numerical score to evaluate the baby's condition at 1 minute after birth.

Context: Perinatal statistics: required to analyse pregnancy outcome, particularly after complications of pregnancy, labour and birth. The Apgar score is an indicator of the health of a baby.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 2 *Max.* 2 *Representational layout:* NN

Data domain: Apgar score (00-10), or 99 (not stated)

Guide for use: The score is based on the five characteristics of heart rate, respiratory condition, muscle tone, reflexes and colour. The maximum or best score being 10.

Verification rules:

Collection methods:

Related data: is a qualifier of Status of the baby, version 1
supersedes previous data element Apgar score, version 1

Administrative attributes

Source document:

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Comments:

Apgar score at 5 minutes

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000345 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Numerical score to evaluate the baby's condition at 5 minutes after birth.

Context: Perinatal statistics: required to analyse pregnancy outcome, particularly after complications of pregnancy, labour and birth. The Apgar score is an indicator of the health of a baby.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 2 *Max.* 2 *Representational layout:* NN

Data domain: Apgar score (00-10), or 99 (not stated)

Guide for use: The score is based on the five characteristics of heart rate, respiratory condition, muscle tone, reflexes and colour. The maximum or best score being 10.

Verification rules:

Collection methods:

Related data: supersedes previous data element Apgar score, version 1

Administrative attributes

Source document:

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Comments:

Complications of pregnancy

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000028 *Version number:* 2

Data element 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 foetus and perinatal morbidity.

Relational and representational attributes

Datatype: Alphanumeric *Representational form:* CODE

Field size: *Min.* 3 *Max.* 6 *Representational layout:* NNN.NN

Data domain: ICD-10-AM – disease codes

Guide for use: Examples of these conditions include threatened abortion, antepartum haemorrhage, pregnancy-induced hypertension and gestational diabetes. There is no arbitrary limit on the number of complications specified.

New South Wales, Australian Capital Territory, Victoria and the Northern Territory implemented ICD-10-AM from 1 July 1998. Other States will implement ICD-10-AM from 1 July 1999.

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

Collection methods:

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

is used in conjunction with Maternal medical conditions, version 2

Administrative attributes

Source document: International Statistical Classification of Diseases and Related Health Problems - Tenth Revision – Australian Modification (1998) National Centre for Classification in Health, Sydney.

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Comments:

Date of completion of last previous pregnancy

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000037 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Date on which the pregnancy preceding the current pregnancy was completed.

Context: Perinatal statistics: interval between pregnancies may be an important risk factor for the outcome of the current pregnancy, especially for preterm birth and low birthweight.

Relational and representational attributes

Datatype: Numeric *Representational form:* DATE

Field size: *Min.* 6 *Max.* 8 *Representational layout:* DDMMYYYY

Data domain: Valid dates

Guide for use: Estimate DD, if first day is unknown.

Verification rules:

Collection methods:

Related data: is a qualifier of Previous pregnancies, version 1
is qualified by Outcome of last previous pregnancy, version 1

Administrative attributes

Source document:

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Comments: This data item is recommended by the World Health Organization. It is currently collected in some States and Territories.

Outcome of last previous pregnancy

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000114 *Version number:* 1

Data element 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

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* 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 foetal loss before 20 weeks, code on outcome of surviving foetus(es) beyond 20 weeks.

Verification rules:

Collection methods:

Related data: is a qualifier of Date of completion of last previous pregnancy, version 1

Administrative attributes

Source document:

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Comments: This data item is recommended by the World Health Organization. It is collected in some States and Territories.

First day of the last menstrual period

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000056 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Date of the first day of the mother's last menstrual period (LMP).

Context: Perinatal statistics: the first day of the LMP is required to estimate gestational age, which is a key outcome of pregnancy and an important risk factor for neonatal outcomes. Although the date of the LMP may not be known, or may sometimes be erroneous, estimation of gestational age based on clinical assessment may also be inaccurate. Both methods of assessing gestational age are required for analysis of outcomes.

Relational and representational attributes

Datatype: Numeric *Representational form:* DATE

Field size: *Min.* 8 *Max.* 8 *Representational layout:* DDMMYYYY

Data domain: Valid dates or 99999999 if first day is unknown

Guide for use: If the first day is unknown, it is unnecessary to record the month and year (i.e. record 99999999).

Verification rules:

Collection methods:

Related data: is used in the calculation of Gestational age, version 1

Administrative attributes

Source document:

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Perinatal from 1/07/97 to

Comments:

Maternal medical conditions

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000090 *Version number:* 2

Data element 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 foetus and perinatal morbidity.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 3 *Max.* 6 *Representational layout:* ANN.NN

Data domain: ICD-10-AM – disease codes

Guide for use: Examples of such conditions include essential hypertension, psychiatric disorders, diabetes mellitus, epilepsy, cardiac disease and chronic renal disease. There is no arbitrary limit on the number of conditions specified.
New South Wales, Australian Capital Territory, Victoria and the Northern Territory implemented ICD-10-AM from 1 July 1998. Other States will implement ICD-10-AM from 1 July 1999.

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

Collection methods:

Related data: supersedes previous data element Maternal medical conditions – ICD-9-CM code, version 1
is used in conjunction with Complications of pregnancy, version 2

Administrative attributes

Source document: International Statistical Classification of Diseases and Related Health Problems – Tenth Revision – Australian Modification (1998) National Centre for Classification in Health, Sydney.

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Comments:

Gestational age

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000059 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

Definition: The duration of gestation is measured from the first day of the last normal menstrual period. Gestational age is expressed in completed days or completed weeks (e.g. events occurring 280 to 286 completed days after the onset of the last normal menstrual period are considered to have occurred at 40 weeks of gestation).

WHO identifies the following categories:

Pre-term: less than 37 completed weeks (less than 259 days) of gestation

Term: from 37 completed weeks to less than 42 completed weeks (259 to 293 days) of gestation

Post-term: 42 completed weeks or more (294 days or more) of gestation.

Context: Perinatal

Relational and representational attributes

Datatype: *Representational form:*

Field size: *Min.* *Max.* *Representational layout:*

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data: relates to the data element Gestational age, version 1

Administrative attributes

Source document:

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Perinatal from 1/07/97 to

Comments:

Gestational age

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000060 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The estimated gestational age of the baby in completed weeks as determined by clinical assessment.

Context: Perinatal statistics: the first day of the LMP is required to estimate gestational age, which is a key outcome of pregnancy and an important risk factor for neonatal outcomes. Although the date of the LMP may not be known, or may sometimes be erroneous, estimation of gestational age based on clinical assessment may also be inaccurate. Both methods of assessing gestational age are required for analysis of outcomes.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 2 *Max.* 2 *Representational layout:* NN

Data domain: Number representing the number of completed weeks, or 99 for not stated / unknown.

Guide for use: This is derived from clinical assessment when accurate information on the date of the last menstrual period (LMP) is not available for this pregnancy.

Gestational age is frequently a source of confusion when calculations are based on menstrual dates. For the purposes of calculation of gestational age from the date of the first day of the last normal menstrual period and the date of delivery, it should be borne in mind that the first day is day zero and not day one.

Verification rules:

Collection methods:

Related data: relates to the data element concept Gestational age, version 1
is calculated using First day of the last menstrual period, version 1

Administrative attributes

Source document: International Classification of Diseases and Related Health Problems, 10 Revision, WHO, 1992

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Perinatal from 1/07/97 to

Comments:

Congenital malformations

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000030 *Version number:* 2

Data element type: DATA ELEMENT

Definition: Structural abnormalities (including deformations) that are present at birth and diagnosed prior to separation from care.

Context: Institutional health 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

Datatype: Alphanumeric *Representational form:* CODE

Field size: *Min.* 3 *Max.* 6 *Representational layout:* ANN.NN

Data domain: 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 'Congenital malformations – BPA classification').

New South Wales, Australian Capital Territory, Victoria and the Northern Territory implemented ICD-10-AM from 1 July 1998. Other States will implement ICD-10-AM from 1 July 1999.

Verification rules:

Collection methods:

Related data: supersedes previous data element Congenital malformations – ICD-9-CM code, version 1

is used in conjunction with Neonatal morbidity, version 2

Administrative attributes

Source document: International Statistical Classification of Diseases and Related health Problems – 10th Revision, Australian Modification (1998) National Centre for Classification in Health, Sydney.

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Comments:

Congenital malformations – BPA code

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000029 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Structural abnormalities (including deformations) that are present at birth and diagnosed prior to separation from care.

Context: Perinatal statistics: 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

Datatype: Alphanumeric *Representational form:* CODE

Field size: *Min.* 5 *Max.* 5 *Representational layout:* NNNNN

Data domain: British Paediatric Association (BPA) Classification of Diseases (1979)

Guide for use: Coding to the disease classification of ICD-10-AM is the preferred method of coding admitted patients. For perinatal data collection, the use of BPA is preferred as this is more detailed.

Verification rules:

Collection methods:

Related data: is used in conjunction with Neonatal morbidity, version 2

Administrative attributes

Source document: British Paediatric Association Classification of Diseases (1979)

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Comments: There is no arbitrary limit on the number of conditions specified. Most perinatal data groups and birth defects registers in the States and Territories have used the 5-digit British Paediatric Association (BPA) Classification of Diseases to code congenital malformations since the early 1980s. The use of the classification is to be reviewed with the introduction of ICD-10.

Infant weight, neonate, stillborn

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000010 *Version number:* 3

Data element type: DATA ELEMENT

Definition: The first weight of the live born or stillborn baby obtained after birth, or the weight of the neonate or infant on the date admitted if this is different from the date of birth.

Context: Weight is an important indicator of pregnancy outcome, is a major risk factor for neonatal morbidity and mortality and is required to analyse perinatal services for high-risk infants.
This item is required to generate Australian Refined Diagnosis Related Groups.

Relational and representational attributes

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 4 *Max.* 4 *Representational layout:* NNNN

Data domain: 4-digit field representing the weight in grams

Guide for use: 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.

In perinatal collections the birthweight is to be provided for liveborn and stillborn babies.

Weight on the date the infant is admitted should be recorded if the weight is less than or equal to 9000g and age is less than 365 days.

Verification rules: For the provision of State and Territory hospital data to Commonwealth agencies this field must be consistent with diagnoses and procedure codes for valid grouping.

Collection methods:

Related data: is used in the derivation of Diagnosis related group, version 1
supersedes previous data element Stillborn, live born baby, infant weight, version 2

Administrative attributes

Source document:

Source organisation: National Health Data Committee

National minimum data sets:

Institutional health care from 1/07/89 to

Perinatal from 1/07/97 to

Comments:

Status of the baby

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000159 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Status of the baby at birth.

Context: Perinatal statistics: essential to analyse outcome of pregnancy.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1	Live birth
2	Stillbirth (foetal 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 (WHO, 1992 definition).

Stillbirth is a foetal 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 foetus 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 foetal death, except that there are no limits of gestational age or birthweight for the WHO definition.)

Verification rules:

Collection methods:

Related data:

- relates to the data element concept Live birth, version 1
- relates to the data element concept Stillbirth (foetal death), version 1
- is used in conjunction with Resuscitation of baby, version 1
- is qualified by Apgar score at 1 minute, version 1

Administrative attributes

Source document:

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Perinatal from 1/07/97 to

Comments:

Perinatal period

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000124 *Version number:* 1

Data element type: DATA ELEMENT CONCEPT

Definition: The perinatal period commences at 20 completed weeks (140 days) of gestation and ends 28 completed days after birth.

Context: Perinatal

Relational and representational attributes

Datatype: *Representational form:*

Field size: *Min.* *Max.* *Representational layout:*

Data domain:

Guide for use:

Verification rules:

Collection methods:

Related data:

Administrative attributes

Source document:

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Perinatal from 1/07/97 to

Comments: This definition of perinatal period differs from that recommended by WHO. In the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems, (WHO, 1992) the perinatal period is defined as commencing: 'at 22 completed weeks (154 days) of gestation (the time when birthweight is normally 500 g) and ends seven completed days after birth'.

At the time that WHO first recommended 500 g (and now 22 weeks) as the lower limits for reporting perinatal and infant mortality, Australia had already adopted legal and statistical definitions for birthweight (400 g) and gestational age (20 weeks) limits that were lower than the WHO limits. Also, the upper limit for the perinatal period in Australia was 28 days. These broader definitions in Australia obviously comply with, and extend, the WHO definitions.

To avoid unnecessary confusion between legal and statistical definitions in Australia, for the purposes of perinatal data collection it is recommended that the perinatal period commences at 20 completed weeks (140 days) of gestation and ends 28 completed days after birth.

Perineal status

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000125 *Version number:* 1

Data element type: DATA ELEMENT

Definition: State of the perineum following birth.

Context: Perinatal statistics: perineal laceration (tear) may cause significant maternal morbidity in the postnatal period. Episiotomy is an indicator of management during labour and, to some extent, of intervention rates.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* N

Data domain:

1	Intact
2	1st degree laceration/vaginal graze
3	2nd degree laceration
4	3rd degree laceration
5	Episiotomy
6	Combined laceration and episiotomy
8	Other
9	Not stated

Guide for use:

Verification rules:

Collection methods:

Related data: is used in conjunction with Anaesthesia administered during labour, version 1
is used in conjunction with Presentation at birth, version 1
is used in conjunction with Method of birth, version 1

Administrative attributes

Source document:

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Comments:

Postpartum complication

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000131 *Version number:* 2

Data element 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

Datatype: Alphanumeric *Representational form:* CODE

Field size: *Min.* 3 *Max.* 6 *Representational layout:* ANN.NN

Data domain: ICD-10-AM

Guide for use: There is no arbitrary limit on the number of conditions specified.
New South Wales, Australian Capital Territory, Victoria and the Northern Territory implemented ICD-10-AM from 1 July 1998. Other States will implement ICD-10-AM from 1 July 1999.

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

Collection methods:

Related data: is used in conjunction with Complication of labour and delivery, version 2

Administrative attributes

Source document: International Statistical Classification of Diseases and Related health Problems – 10th Revision, Australian Modification (1998) National Centre for Classification in Health, Sydney.

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

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.

Previous pregnancies

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000134 *Version number:* 1

Data element 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

Datatype: Numeric *Representational form:* QUANTITATIVE VALUE

Field size: *Min.* 2 *Max.* 2 *Representational layout:* NN

Data domain: 2-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.

Verification rules:

Collection methods:

Related data: is qualified by Date of completion of last previous pregnancy, version 1
is used in conjunction with Outcome of last previous pregnancy, version 1

Previous pregnancies (*continued*)

Administrative attributes

Source document:

Source organisation: National Perinatal Data Development Committee

National minimum data sets:

Comments:

Behaviour-related nursing requirements – at nursing home admission

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000018 *Version number:* 1

Data element type: DATA ELEMENT

Definition: A measure of the additional nursing and personal care time for nursing home residents at the time of admission required for nursing home residents resulting from certain behaviour (normally arising from the resident's mental state) such as disorientation, confusion, aggression, severe agitation or extreme anxiety, wandering and noisiness, and disruptive or self-destructive behaviour. Note that this is not intended to cover the routine or normal levels of social and emotional support.

Context: Nursing home statistics: along with functional profile, continence and specialised nursing procedures, behaviour constitutes one of the key indicators of dependency and disability for nursing home residents and serves to supplement Resident Classification Instrument level of dependency which is also in the dictionary.

Relational and representational attributes

Datatype: Alphabetic *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* A

Data domain:

A	For additional attention
B	Less than 0.5 hours of direct individual attention per day
C	From 0.5 to 1.5 hours of individual attention per day or attention for two or more hours at least once a week on an episodic basis
D	More than 1.5 hours of individual attention per day

Guide for use:

Verification rules:

Collection methods: This item is based on the Resident Classification Instrument, which has been replaced.

Related data:

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

Comments: This data element is subject to review during 1999.

Behaviour-related nursing requirements – at nursing home, current status

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000374 *Version number:* 1

Data element type: DATA ELEMENT

Definition: A measure of the current status of additional nursing and personal care time required for nursing home residents resulting from certain behaviour (normally arising from the resident's mental state) such as disorientation, confusion, aggression, severe agitation or extreme anxiety, wandering and noisiness, and disruptive or self-destructive behaviour. Note that this is not intended to cover the routine or normal levels of social and emotional support.

Context: Nursing home statistics: along with functional profile, continence and specialised nursing procedures, behaviour constitutes one of the key indicators of dependency and disability for nursing home residents and serves to supplement Resident Classification Instrument level of dependency which is also in the dictionary.

Relational and representational attributes

Datatype: Alphabetic *Representational form:* CODE

Field size: Min. 1 Max. 1 *Representational layout:* A

Data domain:

A	For additional attention
B	Less than 0.5 hours of direct individual attention per day
C	From 0.5 to 1.5 hours of individual attention per day or attention for two or more hours at least once a week on an episodic basis
D	More than 1.5 hours of individual attention per day

Guide for use:

Verification rules:

Collection methods: This item is based on the Resident Classification Instrument, which has been replaced.

Related data:

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

Comments: This data element is subject to review during 1999.

Continence status (faeces) of nursing home resident – at admission

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000033 *Version number:* 2

Data element type: DATA ELEMENT

Definition: A measure of the level of incontinence (faeces) of a person at the time of admission to a nursing home in terms of the frequency with which the resident is incontinent.

Context: Nursing home statistics: along with continence, behaviour and specialised nursing procedures, functional profile constitutes one of the key indicators of dependency and disability for nursing home residents and serves to supplement the Resident Classification Instrument level of dependency.

Relational and representational attributes

Datatype: Alphanumeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* A

Data domain:

A	Continent
B	Incontinent, but not daily
C	Incontinent, occurring once daily
D	Incontinent, occurring regularly more than once daily

Guide for use:

Verification rules:

Collection methods: This item is based on the Resident Classification Instrument, which has been replaced.

Related data: supersedes previous data element Continence status at admission, version 1

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

Comments: This data element is subject to review during 1999.

Contenance status (faeces) of nursing home resident – current status

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000034 *Version number:* 2

Data element type: DATA ELEMENT

Definition: A measure of the nursing home resident's current level of incontinence (faeces) in terms of the frequency with which the resident is incontinent.

Context: Nursing home statistics: along with continence, behaviour and specialised nursing procedures, functional profile constitutes one of the key indicators of dependency and disability for nursing home residents and serves to supplement the Resident Classification Instrument level of dependency.

Relational and representational attributes

Datatype: Alphanumeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* A

Data domain:

A	Continent
B	Incontinent, but not daily
C	Incontinent, occurring once daily
D	Incontinent, occurring regularly more than once daily

Guide for use:

Verification rules:

Collection methods: This item is based on the Resident Classification Instrument, which has been replaced.

Related data:

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

Comments: This data element is subject to review during 1999.

Continence status (urine) of nursing home resident – at admission

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000375 *Version number:* 2

Data element type: DATA ELEMENT

Definition: A measure of the level of incontinence (urine) of a person at the time of admission to a nursing home in terms of the frequency with which the resident is incontinent.

Context: Nursing home statistics: along with continence, behaviour and specialised nursing procedures, functional profile constitutes one of the key indicators of dependency and disability for nursing home residents and serves to supplement the Resident Classification Instrument level of dependency.

Relational and representational attributes

Datatype: Alphanumeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* A

Data domain:

A	Continent
B	Incontinent, but not daily
C	Incontinent, occurring once daily
D	Incontinent, occurring regularly more than once daily

Guide for use:

Verification rules:

Collection methods: This item is based on the Resident Classification Instrument, which has been replaced.

Related data:

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

Comments: This data element is subject to review during 1999.

Continence status (urine) of nursing home resident – current status

Admin. status: CURRENT 1/07/97

Identifying and definitional attributes

Knowledgebase ID: 000376 *Version number:* 2

Data element type: DATA ELEMENT

Definition: A measure of the nursing home resident's current level of incontinence (urine) in terms of the frequency with which the resident is incontinent.

Context: Nursing home statistics: along with continence, behaviour and specialised nursing procedures, functional profile constitutes one of the key indicators of dependency and disability for nursing home residents and serves to supplement the Resident Classification Instrument level of dependency.

Relational and representational attributes

Datatype: Alphabetic *Representational form:* CODE

Field size: Min. 1 Max. 1 *Representational layout:* A

Data domain:

A	Continent
B	Incontinent, but not daily
C	Incontinent, occurring once daily
D	Incontinent, occurring regularly more than once daily

Guide for use:

Verification rules:

Collection methods: This item is based on the Resident Classification Instrument, which has been replaced.

Related data:

Administrative attributes

Source document:

Source organisation:

National minimum data sets:

Comments: This data element is subject to review during 1999.

Functional profile of nursing home resident – at admission

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000057 *Version number:* 1

Data element type: DATA ELEMENT

Definition: A measure of the extent to which a person requires assistance in relation to a range of normal activities at the time of admission to a nursing home.

Context: Nursing home statistics: along with continence, behaviour and specialised nursing procedures, functional profile constitutes one of the key indicators of dependency and disability for nursing home residents and serves to supplement the Resident Classification Instrument level of dependency.

Relational and representational attributes

Datatype: Alphanumeric *Representational form:* CODE

Field size: *Min.* 2 *Max.* 2 *Representational layout:* AN

Data domain: Code comprising alphabetic (A-D) and numeric value (1-5)

- 1 Transferring to / from bed / chair / walking aid
- 2 Mobility
- 3 Bath / shower
- 4 Dressing / undressing (including fitting of artificial limbs and appliances)
- 5 Eating (fluids and solid food)
- A Requires no assistance
- B Requires observation / encouragement but no hands-on assistance
- C Requires some hands-on assistance
- D Requires full assistance

Guide for use:

Verification rules:

Collection methods: This item is based on the Resident Classification Instrument, which has been replaced.

Related data:

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

Comments: This data element is subject to review during 1999.

Functional profile of nursing home resident – current status

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000058 *Version number:* 1

Data element type: DATA ELEMENT

Definition: A measure of the extent to which a nursing home resident requires assistance in relation to a range of normal activities.

Context: Nursing home statistics: along with continence, behaviour and specialised nursing procedures, functional profile constitutes one of the key indicators of dependency and disability for nursing home residents and serves to supplement the Resident Classification Instrument level of dependency.

Relational and representational attributes

Datatype: Alphanumeric *Representational form:* CODE

Field size: *Min.* 2 *Max.* 2 *Representational layout:* AN

Data domain: Code comprising alphabetic (A-D) and numeric value (1-5)

- 1 Transferring to / from bed / chair / walking aid
- 2 Mobility
- 3 Bath / shower
- 4 Dressing / undressing (including fitting of artificial limbs and appliances)
- 5 Eating (fluids and solid food)
- A Requires no assistance
- B Requires observation / encouragement but no hands-on assistance
- C Requires some hands-on assistance
- D Requires full assistance

Guide for use:

Verification rules:

Collection methods: This item is based on the Resident Classification Instrument, which has been replaced.

Related data:

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

Comments: This data element is subject to review during 1999.

Specialised nursing requirements – at nursing home admission

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000153 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The additional nursing and personal care attention required at the time of admission to a nursing home as a result of the resident needing specialised nursing procedures, such as colostomy/catheter care, unstable diabetes management. This is not intended to include time spent in relation to routine nursing procedures.

Context: Nursing home statistics: along with functional profile, continence and behaviour, specialised nursing procedures constitute one of the key indicators of dependency and disability for nursing home residents and serve to supplement the Resident Classification Instrument dependency level. The data item has been based on the Resident Classification Instrument rather than the NH5 because the NH5 only provides the status at or before admission and does not provide current status.

Relational and representational attributes

Datatype: Alphabetic *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* A

Data domain:

A	No specialised nursing procedures
B	Less than 0.5 hours of attention per day
C	From 0.5 to 1.5 hours of attention per day
D	More than 1 hour of attention per day

Guide for use:

Verification rules:

Collection methods: This item is based on the Resident Classification Instrument, which has been replaced.

Related data:

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

Comments: This data element is subject to review during 1999.

Specialised nursing requirements – current status

Admin. status: CURRENT 1/07/89

Identifying and definitional attributes

Knowledgebase ID: 000154 *Version number:* 1

Data element type: DATA ELEMENT

Definition: A nursing home resident's current requirement for additional nursing and personal care attention as a result of the resident needing specialised nursing procedures, such as colostomy/catheter care, unstable diabetes management. This is not intended to include time spent in relation to routine nursing procedures.

Context: Nursing home statistics: along with functional profile, continence and behaviour, specialised nursing procedures constitute one of the key indicators of dependency and disability for nursing home residents and serve to supplement the Resident Classification Instrument dependency level. The data item has been based on the Resident Classification Instrument rather than the NH5 because the NH5 only provides the status at or before admission and does not provide current status.

Relational and representational attributes

Datatype: Alphabetic *Representational form:* CODE

Field size: *Min.* 1 *Max.* 1 *Representational layout:* A

Data domain:

A	No specialised nursing procedures
B	Less than 0.5 hours of attention per day
C	From 0.5 to 1.5 hours of attention per day
D	More than 1 hour of attention per day

Guide for use:

Verification rules:

Collection methods: This item is based on the Resident Classification Instrument, which has been replaced.

Related data:

Administrative attributes

Source document:

Source organisation: National minimum data set working parties

National minimum data sets:

Comments: This data element is subject to review during 1999.

Bodily location of main injury

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000086 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The bodily location of the injury chiefly responsible for the attendance of the person at the health care facility.

Context: Injury surveillance: the injury diagnosis is necessary for purposes including epidemiological research, casemix studies and planning. The data element Nature of main injury – non-admitted patient together with data element Bodily location of main injury indicates the diagnosis.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 2 *Max.* 2 *Representational layout:* NN

Data domain:

01	Head (excludes face [02])
02	Face (excludes eye)
03	Neck
04	Thorax
05	Abdomen
06	Lower back (includes loin)
07	Pelvis (includes perineum, anogenital area and buttocks)
08	Shoulder
09	Upper arm
10	Elbow
11	Forearm
12	Wrist
13	Hand (include fingers)
14	Hip
15	Thigh
16	Knee
17	Lower leg
18	Ankle
19	Foot (include toes)
20	Unspecified bodily location
21	Multiple injuries (involving more than one bodily location)
22	Bodily location not required

Guide for use: If the full ICD-10-AM code is used to code the injury, this item is not required (see data elements Principal diagnosis and Additional diagnosis). New South Wales, Australian Capital Territory, Victoria and the Northern Territory implemented ICD-10-AM from 1 July 1998. Other States will implement ICD-10-AM from 1 July 1999.

Bodily location of main injury (*continued*)

Guide for use (cont'd): If any code from 01 to 12 or 26 to 29 in the data element Nature of main injury has been selected, the body region affected by that injury must be specified.

Select the category that best describes the location of the injury. If two or more categories are judged to be equally appropriate, select the one that comes first on the code list. A major injury, if present, should always be coded rather than a minor injury. If a major injury has been sustained (e.g. a fractured femur), along with one or more minor injuries (e.g. some small abrasions), the major injury should be coded in preference to coding 'multiple injuries'. As a general guide, an injury which, on its own, would be unlikely to have led to the attendance may be regarded as 'minor'. Bodily location of main injury code is not required with other Nature of main injury codes (code 22 may be used as a filler to indicate that a specific body region code is not required).

Verification rules:

Collection methods:

Related data: is used in conjunction with Nature of main injury – non-admitted patient, version 1

Administrative attributes

Source document:

Source organisation: Australian Institute of Health and Welfare National Injury Surveillance Unit and National Data Standards for Injury Surveillance Advisory Group

National minimum data sets:

Injury surveillance from 1/07/89 to

Comments: This item is related to the ICD-10-AM injury and poisoning classification. However, coding to the full ICD-10-AM injury and poisoning classification (see data element Principal diagnosis) is not available in most settings where basic injury surveillance is undertaken. This item, in combination with the data element Nature of main injury – non-admitted patient, is a practicable alternative. Data coded to the full ICD-10-AM codes can be aggregated to match this item, facilitating data comparison. Further information on the national injury surveillance program can be obtained from the National Injury Surveillance Unit, Flinders University, Adelaide.

Nature of main injury – non-admitted patient

Admin. status: CURRENT 1/07/96

Identifying and definitional attributes

Knowledgebase ID: 000087 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The nature of the injury chiefly responsible for the attendance of the person at the health care facility.

Context: Injury surveillance: injury diagnosis is necessary for purposes including epidemiological research, casemix studies and planning. This item together with item 'Bodily location of main injury' indicates the diagnosis.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 2 *Max.* 4 *Representational layout:* NN or NN.N

Data domain:

01	Superficial (excludes eye [13])
02	Open wound (excludes eye [13])
03	Fracture (excludes tooth [21])
04	Dislocation (includes ruptured disc, cartilage, ligament)
05	Sprain or strain
06	Injury to nerve (includes spinal cord; excludes intracranial injury [20])
07	Injury to blood vessel
08	Injury to muscle or tendon
09	Crushing injury
10	Traumatic amputation (includes partial amputation)
11	Injury to internal organ
12	Burn or corrosion (excludes eye [13])
13	Eye injury (excludes foreign body in external eye [14.1], includes burns)
14.1	Foreign body in external eye
14.2	Foreign body in ear canal
14.3	Foreign body in nose
14.4	Foreign body in respiratory tract (excludes foreign body in nose [14.3])
14.5	Foreign body in alimentary tract
14.6	Foreign body in genitourinary tract
14.7	Foreign body in soft tissue
14.9	Foreign body, other/ unspecified
20	Intracranial injury (includes concussion)
21	Dental injury (includes fractured tooth)
22	Drowning, immersion
23	Asphyxia or other threat to breathing (excludes drowning [22])

Nature of main injury – non-admitted patient (*continued*)

Data domain (cont'd):	24	Electrical injury
	25	Poisoning, toxic effect (excludes venomous bite [26])
	26	Effect of venom, or any insect bite
	27	Other specified nature of injury
	28	Injury of unspecified nature
	29	Multiple injuries of more than one 'nature'
	30	No injury detected

Guide for use: If the full ICD-10-AM code is used to code the injury, this item is not required (see data elements Principal diagnosis and Additional diagnosis).

When coding to the full ICD-10-AM code is not possible, use this item with the data element External cause of injury – non admitted patient, External cause of injury – human intent and Bodily location of main injury.

Select the item which best characterises the nature of the injury chiefly responsible for the attendance, 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. A major injury, if present, should always be coded rather than a minor injury. If a major injury has been sustained (e.g. a fractured femur), along with one or more minor injuries (e.g. some small abrasions), the major injury should be coded in preference to coding 'multiple injuries'. As a general guide, an injury which, on its own, would be unlikely to have led to the attendance may be regarded as 'minor'.

If the nature of the injury code is 01 to 12 or 26 to 29 then data element Bodily location of main injury should be used to record the bodily location of the injury. If another code is used, bodily location is implicit or meaningless. Data element Bodily location of main injury, category 22 may be used as a filler to indicate that specific body region is not required.

New South Wales, Victoria, Australian Capital Territory and Northern Territory implemented ICD-10-AM from 1 July 1998. Other States will implement ICD-10-AM from 1 July 1999

Verification rules: Left justified, zero filled.

Collection methods:

Related data: is used in conjunction with External cause – major external cause, version 3
 is used in conjunction with External cause – human intent, version 3
 is used in conjunction with Bodily location of main injury, version 1

Administrative attributes

Source document:

Source organisation: Australian Institute of Health and Welfare National Injury Surveillance Unit and National Data Standards for Injury Surveillance Advisory Group

National minimum data sets:

Injury surveillance from 1/07/89 to

Nature of main injury – non-admitted patient (*continued*)

Comments:

This item is related to the ICD-10-AM injury and poisoning classification. However, coding to the full ICD-10-AM injury and poisoning classification (see data element Principal diagnosis) is not available in most settings where basic injury surveillance is undertaken. This item, in combination with the data element Bodily location of main injury, is a practicable alternative. Data coded to the full ICD-10-AM codes can be aggregated to match this item, facilitating data comparison. Further information on the national injury surveillance program can be obtained from the National Injury Surveillance Unit, Flinders University, Adelaide.

Dependency in activities of daily living

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000309 *Version number:* 2

Data element type: DATA ELEMENT

Definition: An indicator of a person's ability to carry out activities of daily living without assistance.

Context: Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored.

It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.

The following is an example of the minimum items, which are indicative of dependency.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 1 *Max.* 3 *Representational layout:* NNN

Data domain: All items must be completed. Select the appropriate code from the options provided for each of the above dependency items.

- a) Mobility* 1 2 3 4
- b) Toileting 1 2 3 4
- c) Transferring 1 2 3 4 5
- d) Bathing 1 2 3 4
- e) Dressing 1 2 3 4
- f) Eating 1 2 3 4 5
- g) Bed mobility 1 2 3 4 5
- h) Bladder continence 1 2 3 4 5 6
- i) Bowel continence 1 2 3 4 5
- j) Extra surveillance* 1 2 3 4 5 6 7
- k) Technical care** not required, or time in minutes

Guide for use: Services may elect to adopt the measures as defined in this item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc. Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

Dependency in activities of daily living (*continued*)

Guide for use (cont'd): All items must be completed

Select the appropriate code from the options provided for activities a) to g) when:

1 = Independent

2 = Requires observation or rare physical assistance

3 = Cannot perform the activity without some assistance

4 = Full assistance required (totally dependent); for bed mobility – a hoist is used

5 = For transferring – person is bedfast; for eating – tube-fed only; for bed mobility – 2 persons physical assist is required

* applies to walking, walking aid or wheelchair

Select the appropriate code for h) Bladder continence when:

1=Continent of urine (includes independence in use of device)

2=Incontinent less than daily

3=Incontinent once per 24 hour period

4=Incontinent 2-6 times per 24 hour period

5=Incontinent more than 6 times per 24 hour period

6=Incontinent more than once at night only

Select the appropriate code for I) Bowel continence when:

1 = Continent of faeces (includes independence in use of device)

2 = Incontinent less than daily

3 = Incontinent once per 24 hour period

4 = Incontinent regularly, more than once per 24 hour period

5 = Incontinent more than once at night only

Select the appropriate code for j) Extra surveillance* when:

1 = No additional attention required

2 = Less than 30 minutes individual attention per day

3 = More than 30 and more than or equal to 90 minutes individual attention per day

4 = Requires at least two hours intervention per week on an episodic basis

5 = More than 90 minutes but less than almost constant individual attention

6 = Requires almost constant individual attention

7 = Cannot be left alone at all

* Extra surveillance refers to behaviour, which requires individual attention and/or planned intervention. Some examples of extra surveillance are:

- aggressiveness;

- wandering;

- impaired memory or attention;

- disinhibition and other cognitive impairment.

Dependency in activities of daily living (*continued*)

Guide for use (cont'd): Select the appropriate code for k) Technical care** not required, or time in minutes, when:

1 = No technical care requirements

or

___ = Daytime technical (minutes per week)

___ = Evening technical (minutes per week)

___ = Night-time technical (minutes per week)

___ = Infrequent technical (minutes per month)

** Technical care refers to technical tasks and procedures for which nurses receive specific education and which require nursing knowledge of expected therapeutic effect, possible side-effects, complications and appropriate actions related to each. In the community nursing setting, carers may undertake some of these activities within, and under surveillance, of a nursing care-plan. Some examples of technical care activities are:

- medication administration (including injections);
- dressings and other procedures;
- venipuncture;
- monitoring of dialysis;
- implementation of pain management technology.

Verification rules:

Collection methods: Commencement of Care episode. (There may be several visits in which assessment data are gathered.)

Related data: supersedes previous data element Client dependency, version 1

Administrative attributes

Source document:

Source organisation: Australian Council of Community Nursing Services

National minimum data sets:

Comments: There are a significant number of dependency instruments in use in the community and institutional care. The CNMDSA recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The data domain specified in this item consists of a number of standard elements, which can be used to map to and/or score from the majority of them.

Carer availability

Admin. status: CURRENT 1/07/98

Identifying and definitional attributes

Knowledgebase ID: 000022 *Version number:* 2

Data element type: DATA ELEMENT

Definition: A record of whether a person has been identified, such as a family member, friend or neighbour as providing regular on-going care, or assistance which is not linked to a formal service.

Context: The availability of informal care at home is often a determinant of a person's ability to remain in home care, especially if they are highly dependent. It is also an indicator of risk if a vulnerable person lives alone, or has no carer. As the focus of care increasingly moves to the community, it is important to monitor the degree of need, the amount of formal care given, and the presence of a carer. This helps to establish how much of the overall burden is being absorbed by the 'informal' caring system.

Relational and representational attributes

Datatype: Numeric *Representational form:* CODE

Field size: *Min.* 2 *Max.* 2 *Representational layout:* NN

Data domain:

01	Person independent
02	No carer available
03	Has a co-resident carer
04	Has a non-resident carer
05	Lives in a mutually dependent situation
06	Not applicable person in residential care
07	Not stated/inadequately described

Guide for use: This includes people who receive payment such as a special benefit or pension.

This excludes formal services such as delivered meals or home help, persons arranged by formal services such as volunteers, and funded group housing or similar situations. Availability infers carer willingness and ability to undertake the caring role and can apply when there are several carers. Where a potential carer is not prepared to undertake the role, or when their capacity to carry out necessary tasks is minimal, then the person must be coded as not having 'No carer available'.

Where there are several carers, a decision should be taken as to which of these is the main or primary carer and code accordingly. The following descriptions may assist in the selection of the most appropriate data.

Carer availability (*continued*)

- Guide for use (cont'd):**
1. PERSON INDEPENDENT indicates that the person has no need for assistance from informal carers.
 2. NO CARER AVAILABLE means that the person needs a carer but has no one able to provide informal care.
 3. HAS A CO-RESIDENT CARER (excludes Code 5) means that the person has a carer who is living in the same household.
 4. HAS A NON-RESIDENT CARER means that the person has a carer who is living in a different household.
 5. LIVES IN A MUTUALLY DEPENDENT SITUATION (excludes Code 3) refers to those households where the service recipient and another person are mutually dependent. The critical aspect of such households is that if either member becomes unavailable for any reason, the other is either at high risk or unable to remain at home.
 6. NOT APPLICABLE PERSON IN RESIDENTIAL CARE – services are provided by a formal agency in a supported accommodation or other care facility.
 99. NOT STATED/INSUFFICIENTLY DESCRIBED means that there is insufficient information to determine carer availability.

Verification rules:

Collection methods: Carer availability is to be collected at admission and again at discharge. The discharge information refers to the status immediately prior to the discharge, and not the need of the service recipient after the event.

Related data: supersedes previous data element Carer availability, version 1

Administrative attributes

Source document:

Source organisation: Australian Council of Community Nursing Services

National minimum data sets:

Comments: The original item 'Carer Availability' in Version 1.0 of the CNMDSA has been split into two items 'Carer Availability' and 'Living Arrangement'. Users of the CNMDSA found the original item difficult to apply as it was seeking to do two things: describe the carer availability and the person's living arrangements within one item. The new item 'Living Arrangement' is introduced to clarify meaning and describe each item more clearly.

The reason for collection at both admission and discharge is that over a care episode, a change in carer status may occur either because the caring load increases, and/or, the carer's ability or willingness to undertake the role ceases or is diminished. This may necessitate discharge of the person from care, and has implications for health service utilisation. The coding options are therefore identical to enable comparison of the admission and discharge states. The discharge information refers to the person's state when care was being delivered, not after their discharge from care.