Australian Government
Australian Institute of Health and Welfare

National Health Data Dictionary

Version 16.1

NATIONAL HEALTH DATA DICTIONARY SERIES NO. 17

Australian Government
Australian Institute of Health and Welfare

Authoritative information and statistics to promote better health and wellbeing

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Australian Institute of Health and Welfare
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The Australian Institute of Health and Welfare is a major national agency which provides reliable, regular and relevant information and statistics on Australia's health and welfare. The Institute's mission is *authoritative information and statistics to promote better health and wellbeing*.

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Please note that there is the potential for minor revisions of data in this report. Please check the online version at <www.aihw.gov.au> for any amendments.

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Abbreviations

AHMAC	Australian Health Ministers' Advisory Council
AIHW	Australian Institute of Health and Welfare
DSS	data set specification
HAI	healthcare associated infections
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
ICD-O-3	International Classification of Diseases for Oncology, 3rd Edition
ISO/IEC 11179	International Organization for Standardization and the International Electrotechnical Commission 11179 Metadata Registries (International Standard)
METeOR	Metadata Online Registry
NHDD	National Health Data Dictionary
NHIA	National Health Information Agreement
NHIPPC	National Health Information and Performance Principal Committee
NHISSC	National Health Information Standards and Statistics Committee
NMDS	national minimum data set
SAB	*Staphylococcus aureus* bacteraemia
SACC	Standard Australian Classification of Countries

Symbols

▲	new standard data elements
◊	revised standard data elements

1 Introduction

The National Health Data Dictionary (NHDD) is the authoritative source of information about endorsed national metadata standards for the health sector, and provides the basis for consistent national collection and reporting.

The NHDD version 16.1 contains national standards that were approved between May 2012 and the end of June 2013. It follows the publication of NHDD version 16 which reflected changes to the national health data standards between 1 July 2010 and 30 April 2012. The NHDD version 16 is available on the Australian Institute of Health and Welfare's (AIHW's) website, at <www.aihw.gov.au/publication-detail/?id=10737422826>.

Within the NHDD version 16.1, the national standards have been grouped into the following categories:

- data elements
- national minimum data set specifications
- data set specifications
- data element clusters
- supporting metadata items:
  - object classes
  - properties
  - classification schemes
  - glossary items.

The standards have been endorsed by the National Health Information and Performance Principal Committee (NHIPPC) for inclusion in the data dictionary. Further information about the committee governance process can be found in the 'Governance' section later in this chapter.

The standards are also available on METeOR, the AIHW's online metadata registry, at <www.meteor.aihw.gov.au>.

Structure of this publication

To support the use of this publication, the NHDD version 16.1 has been divided into 4 chapters:

- Chapter 1—a brief description of the NHDD, including how metadata are approved as national data standards and the future of the NHDD.
- Chapter 2—a summary of the changes to the national data standards since the previous version of the NHDD.
- Chapter 3—all new and revised national data standards. Data elements are alphabetised by their short names.
- Chapter 4—a list of all new and revised data elements within this publication, alphabetised by their technical names.

Data elements are assigned both a short name and a technical name. Both the short name and the technical name will be unique to the data element. The short name is the designation by which the data element is commonly known. The technical name reflects the metadata that combine to form the data element, and is based on the second edition of the international standard *International Organization for Standardization and the International Electrotechnical Commission 11179 Metadata Registries* (ISO/IEC 11179). For example, the data element technically named 'Person—date of birth, DDMMYYYY' is commonly referred to as 'Date of birth'. The data elements section of Chapter 3 is organised by short name, with Chapter 4 providing an alternative listing (with corresponding page numbers) by technical name.

1.1 What are the national data dictionaries?

National data dictionaries contain standard data definitions and data elements for use in a particular sector. The three national data dictionaries produced by the AIHW contain national standards for use in Australian health, community services, and housing and homelessness data collections respectively. The National Health Data Dictionary, the National Community Services Data Dictionary and the National Housing and Homelessness Data Dictionary are the authoritative sources of information about endorsed national metadata standards and provide the basis for consistent national collection and reporting. The NHDD has been produced under the auspices of the Australian Health Ministers' Advisory Council (AHMAC), with all standards endorsed by NHIPPC.

Where possible, metadata standards in the dictionary are consistent with other national standard classifications to ensure overall comparability of national data. Examples include the 'Australian Statistical Geography Standard', developed by the Australian Bureau of Statistics, and the 'Australian Classification of Health Interventions 8th edition', developed by the National Casemix and Classification Centre.

The national health, community services and housing and homelessness data dictionaries are available online at <www.aihw.gov.au>.

Governance

To date, the national health data dictionaries have been produced as initiatives under the National Health Information Agreement (NHIA). Under the NHIA, all parties commit to ensuring that collection, compilation and interpretation of national information are all appropriate and carried out efficiently. This requires agreement on definitions, standards and rules for collecting information, and on guidelines for coordinating the access, interpretation and publication of national health information. The NHIA is available online at <www.aihw.gov.au/nhissc/>.

The process of developing health metadata standards is overseen by the National Health Information Standards and Statistics Committee (NHISSC), a subcommittee of the NHIPPC. Once developed and agreed, the standards are endorsed by NHIPPC, which is one of several principal committees that report to AHMAC. AHMAC provides support to the Health Council (Australian, state and territory health ministers) under arrangements for the Council of Australian Governments. Further information about the national health information committees and the health data development process can be found in the publication *Creating nationally-consistent health information: Engaging with the national health information committees*, available on the AIHW website at <http://www.aihw.gov.au/publication-detail/?id=60129546545>.

Where to from here?

The NHDD was first published in 1989 as the publication *National Minimum Data Set – Institutional Health Care*. New versions of the NHDD have generally been published every 2 years as hard copies and/or as PDFs, with updates containing changes produced between major versions. With a shift in user preferences for how to access the information contained within the NHDD, this will be one of the last versions published in PDF format.

The NHDD will continue to be maintained and will remain accessible via the NHDD Browser on the METeOR website at <http://meteor.aihw.gov.au/content/index.phtml/itemId/268110>.

1.2 METeOR

The NHDD version 16.1 is extracted from METeOR, the online metadata registry for developing, registering and disseminating metadata, which is based on ISO/IEC 11179. The international standard was applied to METeOR to provide a detailed registry architecture in which metadata standards can be better defined, navigated and managed throughout the data development lifecycle.

METeOR integrates and presents information about:

- the National Health Data Dictionary
- the National Community Services Data Dictionary
- the National Housing and Homelessness Data Dictionary
- national minimum data sets (NMDSs)
- data set specifications (DSSs)
- performance indicator specifications.

METeOR includes:

- data search and browse tools that allow navigation of data standards of varying levels of endorsement across the health, community services and housing and homelessness assistance sectors
- data view, collation and download tools
- data development tools, including areas in which multiple data developers may collaborate on the development of data standards
- data submission tools that enable data developers to submit draft metadata standards for consideration as national standards
- data management tools that allow the registrar to change the registration status of metadata standards under authorisation of one or more registration authorities
- comprehensive guidelines for developing and reviewing metadata.

2 Summary of updates to the National Health Data Dictionary since version 16

This chapter presents an overview of new and revised national standards that have been endorsed between May 2012 and June 2013.

Table 1: Summary of updates

Registration status	National minimum data sets	Data set specifications	Data elements	Classifications	Glossary items
Standards (new)	0	1	24	0	5
Standards (revised)	6	4	37	4	0
Superseded	18	12	89	6	5
Retired	0	3	0	0	0

Table 2: Revised national minimum data sets

NMDS	Description of change	Data elements revised	Data elements added	Data elements removed
Admitted patient mental health care NMDS 2013–14	Revisions made due to changes in the ICD-10-AM classification.	Additional diagnosis (ICD-10-AM 8th edition) Principal diagnosis—episode of care (ICD-10-AM 8th edition)	Nil	Diagnosis related group (AR-DRG v 6) Major diagnostic category (AR-DRG v 6) Country of birth (SACC 2011)
Admitted patient palliative care NMDS 2013–14	Revisions made due to changes in the ICD-10-AM classification and a new type of hospital care.	Additional diagnosis (ICD-10-AM 8th edition) Principal diagnosis—episode of care (ICD-10-AM 8th edition)	Care type, N[N]	Care type, N[N].N
Alcohol and other drug treatment services NMDS 2013–15	Removal of one data element.	Nil	Address—Australian postcode, code (Postcode datafile) {NNNN}	Service delivery outlet—geographic location, code (ASGC 2011) NNNNN
Elective surgery waiting times (census data) NMDS 2013–	NMDS updated to include the next year of reporting.	Nil	Nil	Nil
Elective surgery waiting times (removals data) NMDS 2013–	NMDS updated to include the next year of reporting.	Nil	Nil	Nil
Public dental waiting times NMDS 2013–	Revision of data set type from DSS to NMDS.	Nil	Nil	Nil

Table 3: New data set specifications

Name	Description
Surveillance of healthcare associated infection: *Staphylococcus aureus* bacteraemia DSS	The purpose of this DSS is to support a comprehensive surveillance program of healthcare associated infections (HAI). HAIs are those infections that are not present or incubating at the time of admission to a healthcare program or facility, develop within a healthcare organisation or are produced by micro-organisms acquired during admission. This DSS is intended to support *Staphylococcus aureus* bacteraemia (SAB) surveillance in Australian hospitals. It is designed for the purposes of HAI surveillance, not diagnosis. The value of surveillance as part of a hospital infection control program is supported by high-grade international and national evidence.

Table 4: Revised data set specifications

NMDS	Description of change	Data elements revised	Data elements added	Data elements removed
Acute coronary syndrome (clinical) DSS 2013–	Revisions made due to changes in the ICD-10-AM classification.	Principal diagnosis—episode of care (ICD-10-AM 8th edition)	Nil	Nil
Breast cancer (cancer registries) DSS	Revisions made due to changes in the ICD-O-3 classification.	Date of diagnosis of cancer Cancer staging—M stage code Cancer staging—TNM stage grouping code Laterality of primary cancer Number of regional lymph nodes examined Primary site of cancer (ICD-O-3 code) Cancer staging—T stage code Cancer staging—N stage code	Nil	Nil
Cardiovascular disease (clinical) DSS	Revisions made due to changes in the Standard Australian Classification of Countries and the Australian Standard Classification of Languages.	Australian postcode (address) Country of birth (SACC 2011) Preferred language (ASCL 2011)	Nil	Nil
Injury surveillance DSS 2013–	Revisions made due to changes in the ICD-10-AM classification.	Activity when injured (ICD-10-AM 8th edition) External cause of injury (ICD-10-AM 8th edition) Place of occurrence of external cause of injury (ICD-10-AM 8th edition)	Nil	Nil

Table 5: New data elements

Short name	Technical name
Anaesthesia administered indicator	Birth event—anaesthesia administered indicator, yes/no code N
Analgesia administered indicator	Birth event—analgesia administered indicator, yes/no code N
Antibiotic susceptibility (Methicillin-resistant *Staphylococcus aureus* isolate)	Methicillin-resistant *Staphylococcus aureus* isolate—antibiotic susceptibility, text X[X(39)]
Antibiotic susceptibility indicator (Methicillin-resistant *Staphylococcus aureus* isolate)	Methicillin-resistant *Staphylococcus aureus* isolate—antibiotic susceptibility indicator, yes/no code N
Date of first dental visit	Public dental waiting list episode—date of first visit, DDMMYYYY
Duration of continuous ventilatory support	Episode of admitted patient care—duration of continuous ventilatory support, total hours NNNN
Full-time equivalent staff—mental health consumer and carer workers	Establishment—full-time equivalent staff (paid) (mental health consumer and carer workers), average NNNN.NN
Healthcare associated *Staphylococcus aureus* bacteraemia clinical criteria	Patient episode of *Staphylococcus aureus* bacteraemia—most probable healthcare associated *Staphylococcus aureus* bacteraemia clinical criteria, code N
Laboratory number	Laboratory—organisation identifier, text X[X(39)]
Laboratory result identifier	Laboratory—result identifier, text X[X(39)]
Length of stay in intensive care unit	Episode of admitted patient care—length of stay in intensive care unit, total hours NNNN
Number of group session non-admitted patient service events	Establishment—number of group session non-admitted patient service events, total service events N[NNNNNN]
Number of individual session non-admitted patient service events	Establishment—number of individual session non-admitted patient service events, total service events N[NNNNNN]
Offer of dental care date	Public dental waiting list episode—date of offer of dental care, DDMMYYYY
Patient episodes of healthcare associated *Staphylococcus aureus* bacteraemia	Establishment—number of patient episodes of healthcare associated *Staphylococcus aureus* bacteraemia, total episodes N[NNNN]
Person identifier flag	Person—unique identifier used indicator, yes/no code N
Public dental listing date	Public dental waiting list episode—listing date for care, DDMMYYYY
Public dental waiting list type	Public dental waiting list episode—waiting list type, code N
Specimen collection date	Person—specimen collection date, DDMMYYYY
Specimen collection time	Person—specimen collection time, hhmm
Specimen identifier	Laboratory—specimen identifier, text X[X(39)]
Staphylococcus aureus bacteraemia methicillin susceptibility indicator	Patient episode of *Staphylococcus aureus* bacteraemia—*Staphylococcus aureus* methicillin susceptibility indicator, yes/no code N
Staphylococcus aureus bacteraemia status	Patient episode of *Staphylococcus aureus* bacteraemia—*Staphylococcus aureus* bacteraemia status, code N
Ward/clinical area	Establishment—ward/clinical area name, text X[X(39)]

3 National health data standards—endorsed May 2012–June 2013

This chapter presents new and revised national health data standards, endorsed by NHIPPC between May 2012 and June 2013. These metadata have been grouped into categories for data elements (alphabetised using the data element's short name, which is what the data element is commonly known by), national minimum data sets, data set specifications, classification schemes and glossary items.

Chapter 3—Table of contents

For ease of reference, all data elements have been assigned a ▲ or ◊ symbol. The ▲ symbol denotes the data element is a new data standard, and the ◊ symbol denotes that it has been revised from a previous version. All revised data standards include hyperlinks to previous versions, located on METeOR.

Data elements listed by short name

◊ Activity when injured

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—activity type, code (ICD-10-AM 8th edn) ANNNN
METeOR identifier:	514277
Registration status:	Health, Standard 02/05/2013
Definition:	The type of activity being undertaken by the person when injured, as represented by a code.
Data Element Concept:	Injury event—activity type

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 8th edition
Representation class:	Code
Data type:	String
Format:	ANNNN
Maximum character length:	5

Data element attributes

Collection and usage attributes

Guide for use:	Admitted patient: External cause codes V00 to Y34 must be accompanied by an activity code.
Comments:	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 term is the basis for identifying work-related and sport-related injuries.

Source and reference attributes

Origin:	National Centre for Classification in Health National Injury Surveillance Unit

Relational attributes

Related metadata references:	Supersedes Injury event—activity type, code (ICD-10-AM 7th edn) ANNNN Health, Superseded 02/05/2013

Implementation in Data Set Specifications:

Admitted patient care NMDS 2013-14 Health, Superseded 11/04/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

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

Admitted patient care NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

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

Injury surveillance DSS 2013- Health, Standard 02/05/2013

Implementation start date: 01/07/2013

◊ Additional diagnosis

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—additional diagnosis, code (ICD-10-AM 8th edn) ANN{.N[N]}
METeOR identifier:	514271
Registration status:	Health, Standard 02/05/2013 Tasmanian Health, Final 30/06/2014 National Health Performance Authority, Proposed 12/12/2013
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, as represented by a code.
Data Element Concept:	Episode of care—additional diagnosis

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 8th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:	Record each additional diagnosis relevant to the episode of care in accordance with the ICD-10-AM Australian Coding Standards. 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. Additional diagnoses give information on the conditions that are significant in terms of treatment required, investigations needed and resources used during the episode of care. 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).
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 or attendance at a health care establishment. The additional diagnosis is derived from and must be substantiated by clinical documentation.

Comments:

Additional diagnoses should be interpreted as conditions that affect patient management in terms of requiring any of the following:

- Commencement, alteration or adjustment of therapeutic treatment
- Diagnostic procedures
- Increased clinical care and/or monitoring

In accordance with the Australian Coding Standards, certain conditions that do not meet the above criteria may also be recorded as additional diagnoses.

Additional diagnoses are significant for the allocation of Australian Refined Diagnosis Related Groups. The allocation of patient 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 of condition codes, should be sequenced together with the additional diagnosis codes so that meaning is given to the data for use in injury surveillance and other monitoring activities.

Source and reference attributes

Origin: National Centre for Classification in Health

Relational attributes

Related metadata references:

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v 7) ANNA Health, Standardisation pending 13/03/2013

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v 7) NN Health, Standardisation pending 30/06/2013

Supersedes Episode of care—additional diagnosis, code (ICD-10-AM 7th edn) ANN{.N[N]} Health, Superseded 02/05/2013, National Health Performance Authority, Standard 07/11/2013

Implementation in Data Set Specifications:

Admitted patient care NMDS 2013-14 Health, Superseded 11/04/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Conditional obligation:
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.

Admitted patient care NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:
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.

Admitted patient mental health care NMDS 2013-14 Health, Standard 02/05/2013

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Admitted patient mental health care NMDS 2014-15 Health, Standardisation pending 18/07/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Admitted patient palliative care NMDS 2013-14 Health, Standard 02/05/2013

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

DSS specific information:
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.

Admitted patient palliative care NMDS 2014-15 Health, Standardisation pending 18/07/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

DSS specific information:
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.

Residential mental health care NMDS 2013-14 Health, Superseded 07/03/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Residential mental health care NMDS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Residential mental health care NMDS 2015-16 Health, Candidate 12/08/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

▲ Anaesthesia administered indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—anaesthesia administered indicator, yes/no code N
METeOR identifier:	495466
Registration status:	Health, Standard 07/02/2013
Definition:	An indicator of whether **anaesthesia** was administered to the woman during a birth event, as represented by a code.
Data Element Concept:	Birth event—anaesthesia administered indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use: This data element should be used in conjunction with the data element: *Birth event – type of anaesthesia administered, code N* to obtain information on the type of anaesthesia administered to a woman during the birth event.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: See also Birth event—type of anaesthesia administered, code N[N] Health, Standard 07/02/2013

Implementation in Data Set Specifications:

Perinatal NMDS 2013-14 Health, Superseded 07/03/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Perinatal NMDS 2014- Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Implementation in Indicators: **Used as numerator**

National Core Maternity Indicators: PI 09-General anaesthetic for women giving birth by caesarean section (2013) Health, Candidate 03/07/2014

▲ Analgesia administered indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—analgesia administered indicator, yes/no code N
METeOR identifier:	495381
Registration status:	Health, Standard 07/02/2013
Definition:	An indicator of whether **analgesia** was administered to the woman during a birth event, as represented by a code.
Data Element Concept:	Birth event—analgesia administered indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:	This data element should be used in conjunction with the data element: *Birth event – type of analgesia administered, code N* to obtain information on the type of analgesia administered to a woman during the birth event.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	See also Birth event—type of analgesia administered, code N[N] Health, Standard 07/02/2013
Implementation in Data Set Specifications:	Perinatal NMDS 2013-14 Health, Superseded 07/03/2014 *Implementation start date:* 01/07/2013 *Implementation end date:* 30/06/2014 Perinatal NMDS 2014- Health, Standard 07/03/2014 *Implementation start date:* 01/07/2014 *Implementation end date:* 30/06/2015

▲Antibiotic susceptibility (Methicillin-resistant *Staphylococcus aureus* isolate)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Methicillin-resistant *Staphylococcus aureus* isolate—antibiotic susceptibility, text X[X(39)]
METeOR identifier:	391098
Registration status:	Health, Standard 15/11/2012
Definition:	The antibiotic against which the Methicillin-resistant *Staphylococcus aureus* (MRSA) isolate is tested for susceptibility, as represented by text.
Data Element Concept:	Methicillin-resistant *Staphylococcus aureus* isolate—antibiotic susceptibility

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	X[X(39)]
Maximum character length:	40

Data element attributes

Collection and usage attributes

Guide for use:	Methicillin-resistant *Staphylococcus aureus* (MRSA) is a strain of *Staphylococcus aureus* that can survive treatment with the antibiotics normally used to treat *Staphylococcus aureus* infections. Required for MRSA isolates only, where the *Staphylococcus aureus* is resistant to methicillin. Must be used in conjunction with the data element *Methicillin-resistant* Staphylococcus aureus *isolate – antibiotic susceptibility indicator, yes/no, code N* to indicate the result of each test. For example, if the MRSA isolate is resistant to trimethoprim, the text recorded for *Methicillin-resistant* Staphylococcus aureus *isolate – antibiotic susceptibility, text [X(39)]* would be trimethoprim, and *Methicillin-resistant* Staphylococcus aureus *isolate – antibiotic susceptibility indicator, yes/no, code N* would be 2 (resistant).

Source and reference attributes

Submitting organisation:	Australian Commission on Safety and Quality in Health Care (ACSQHC)
Origin:	ACSQHC Healthcare Associated Infection Technical Working Group

Relational attributes

Related metadata references:

See also Methicillin-resistant *Staphylococcus aureus* isolate—antibiotic susceptibility indicator, yes/no code N Health, Standard 15/11/2012

Implementation in Data Set Specifications:

Surveillance of healthcare associated infection: *Staphylococcus aureus* bacteraemia DSS Health, Standard 15/11/2012

Conditional obligation:
Required for MRSA isolates only, where the *Staphylococcus aureus* is resistant to methicillin.

▲Antibiotic susceptibility indicator (Methicillin-resistant *Staphylococcus aureus* isolate)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Methicillin-resistant *Staphylococcus aureus* isolate—antibiotic susceptibility indicator, yes/no code N
METeOR identifier:	458628
Registration status:	Health, Standard 15/11/2012
Definition:	An indicator of whether the Methicillin-resistant *Staphylococcus aureus* (MRSA) isolate is susceptible to the antibiotic tested, as represented by a code.
Data Element Concept:	Methicillin-resistant *Staphylococcus aureus* isolate—antibiotic susceptibility indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

Supports clinical management by identifying a range of antibiotics that can be used to treat a patient infected with Methicillin-resistant *Staphylococcus aureus* (MRSA).

Required for MRSA isolates only, where the *Staphylococcus aureus* is resistant to methicillin.

CODE 1 Yes

Record if the MRSA isolate is susceptible to the antibiotic.

CODE 2 No

Record if the MRSA isolate is not susceptible (i.e. resistant) to the antibiotic.

Intermediate level resistance is reported as 2 (resistant).

Must be used in conjunction with the metadata item *Methicillin-resistant* Staphylococcus aureus *isolate – antibiotic susceptibility, text [X(39)]* to indicate which antibiotic is tested.

For example, if the MRSA isolate is resistant to trimethoprim, the text recorded for *Methicillin-resistant* Staphylococcus aureus

isolate – antibiotic susceptibility, text [X(39)] would be trimethoprim, and *Methicillin-resistant* Staphylococcus aureus *isolate – antibiotic susceptibility indicator, yes/no code N* would be 2 (resistant).

Source and reference attributes

Submitting organisation:	Australian Commission on Safety and Quality in Health Care (ACSQHC)
Origin:	ACSQHC Healthcare Associated Infection Technical Working Group

Relational attributes

Related metadata references:	See also Methicillin-resistant *Staphylococcus aureus* isolate—antibiotic susceptibility, text X[X(39)] Health, Standard 15/11/2012
Implementation in Data Set Specifications:	Surveillance of healthcare associated infection: *Staphylococcus aureus* bacteraemia DSS Health, Standard 15/11/2012

◊ Care type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Hospital service—care type, code N[N]
METeOR identifier:	491557
Registration status:	Health, Standard 07/02/2013
Definition:	The overall nature of a clinical service provided to an admitted patient during an episode of care (admitted care), or the type of service provided by the hospital for boarders or **posthumous organ procurement** (care other than admitted care), as represented by a code.
Context:	Admitted patient care and hospital activity: For admitted patients, the type of care received will determine the appropriate casemix classification employed to classify the episode of care.
Data Element Concept:	Hospital service—care type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
Admitted care	
1	Acute care
2	Rehabilitation care
3	Palliative care
4	Geriatric evaluation and management
5	Psychogeriatric care
6	Maintenance care
7	Newborn care
8	Other admitted patient care
Care other than admitted care	
9	Organ procurement—posthumous
10	Hospital boarder

Collection and usage attributes

Guide for use:

Admitted care can be one of the following:

CODE 1 Acute care

Acute care is care in which the primary clinical purpose or treatment goal is to:

- manage labour (obstetric)
- cure illness or provide definitive treatment of injury
- perform surgery
- relieve symptoms of illness or injury (excluding palliative care)
- reduce severity of an illness or injury
- protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function
- perform diagnostic or therapeutic procedures.

CODE 2 Rehabilitation care

Rehabilitation care is care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with an impairment, activity limitation or participation restriction due to a health condition. The patient will be capable of actively participating.

Rehabilitation care is always:

- delivered under the management of or informed by a clinician with specialised expertise in rehabilitation, and
- evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record, that includes negotiated goals within specified time frames and formal assessment of functional ability.

CODE 3 Palliative care

Palliative care is care in which the primary clinical purpose or treatment goal is optimisation of the quality of life of a patient with an active and advanced life-limiting illness. The patient will have complex physical, psychosocial and/or spiritual needs.

Palliative care is always:

- delivered under the management of or informed by a clinician with specialised expertise in palliative care, and
- evidenced by an individualised multidisciplinary assessment and management plan, which is documented in the patient's medical record, that covers the physical, psychological, emotional, social and spiritual needs of the patient and negotiated goals.

CODE 4 Geriatric evaluation and management

Geriatric evaluation and management is care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with multi-dimensional needs associated with medical conditions related to ageing, such as tendency to fall, incontinence, reduced mobility and cognitive impairment. The patient may also have complex psychosocial problems.

Geriatric evaluation and management is always:

- delivered under the management of or informed by a clinician with specialised expertise in geriatric evaluation and management, and
- evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record that covers the physical, psychological, emotional and social needs of the patient and includes negotiated goals within indicative time frames and formal assessment of functional ability.

CODE 5 Psychogeriatric care

Psychogeriatric care is care in which the primary clinical purpose or treatment goal is improvement in the functional status, behaviour and/or quality of life for an older patient with significant psychiatric or behavioural disturbance, caused by mental illness, an age-related organic brain impairment or a physical condition.

Psychogeriatric care is always:

- delivered under the management of or informed by a clinician with specialised expertise in psychogeriatric care, and
- evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record, that covers the physical, psychological, emotional and social needs of the patient and includes negotiated goals within indicative time frames and formal assessment of functional ability.

Psychogeriatric care is not applicable if the primary focus of care is acute symptom control.

CODE 6 Maintenance care

Maintenance (or non-acute) care is care in which the primary clinical purpose or treatment goal is support for a patient with impairment, activity limitation or participation restriction due to a health condition. Following assessment or treatment the patient does not require further complex assessment or stabilisation. Patients with a care type of maintenance care often require care over an indefinite period.

CODE 7 Newborn care

Newborn care is initiated when the patient is born in hospital or is nine days old or less at the time of admission. Newborn care continues until the care type changes or the patient is separated:

- patients who turn 10 days of age and do not require clinical care are separated and, if they remain in the hospital, are designated as boarders
- patients who turn 10 days of age and require clinical care continue in a newborn episode of care until separated
- patients aged less than 10 days and not admitted at birth (for example, transferred from another hospital) are admitted with a newborn care type
- patients aged greater than 9 days not previously admitted (for example, transferred from another hospital) are either boarders or admitted with an acute care type

- within a newborn episode of care, until the baby turns 10 days of age, each day is either a qualified or unqualified day
- a newborn is qualified when it meets at least one of the criteria detailed in **Newborn qualification status**.

Within a newborn episode of care, each day after the baby turns 10 days of age is counted as a qualified patient day. Newborn qualified days are equivalent to acute days and may be denoted as such.

CODE 8 Other admitted patient care

Other admitted patient care is care that does not meet the definitions above.

Care other than admitted care can be one of the following:

CODE 9 Organ procurement—posthumous

Organ procurement—posthumous is the procurement of human tissue for the purpose of transplantation from a donor who has been declared brain dead.

Diagnoses and procedures undertaken during this activity, including mechanical ventilation and tissue procurement, should be recorded in accordance with the relevant ICD-10-AM Australian Coding Standards. These patients are not admitted to the hospital but are registered by the hospital.

CODE 10 Hospital boarder

A hospital boarder is a person who is receiving food and/or accommodation at the hospital but for whom the hospital does not accept responsibility for treatment and/or care.

Hospital boarders are not admitted to the hospital. However, a hospital may register a boarder. Babies in hospital at age 9 days or less cannot be boarders. They are admitted patients with each day of stay deemed to be either qualified or unqualified.

Comments: Unqualified newborn days (and separations consisting entirely of unqualified newborn days) are not to be counted for all purposes, and they are ineligible for health insurance benefit purposes.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Steward: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: Only one type of care can be assigned at a time. In cases when a patient is receiving multiple types of care, the care type that best describes the primary clinical purpose or treatment goal should be assigned.

The care type is assigned by the clinician responsible for the management of the care, based on clinical judgements as to the primary clinical purpose of the care to be provided and, for subacute care types, the specialised expertise of the clinician who will be responsible for the management of the care. At the time of subacute care type assignment, a multidisciplinary

management plan may not be in place but the intention to prepare one should be known to the clinician assigning the care type.

Where the primary clinical purpose or treatment goal of the patient changes, the care type is assigned by the clinician who is taking over responsibility for the management of the care of the patient at the time of transfer. Note, in some circumstances the patient may continue to be under the management of the same clinician. Evidence of care type change (including the date of handover, if applicable) should be clearly documented in the patient's medical record.

The clinician responsible for the management of care may not necessarily be located in the same facility as the patient. In these circumstances, a clinician at the patient's location may also have a role in the care of the patient; the expertise of this clinician does not affect the assignment of care type.

The care type should not be retrospectively changed unless it is:

- for the correction of a data recording error, or
- the reason for change is clearly documented in the patient's medical record and it has been approved by the hospital's director of clinical services.

Subacute care is specialised multidisciplinary care in which the primary need for care is optimisation of the patient's functioning and quality of life. A person's functioning may relate to their whole body or a body part, the whole person, or the whole person in a social context, and to impairment of a body function or structure, activity limitation and/or participation restriction.

Subacute care comprises the defined care types of rehabilitation, palliative care, geriatric evaluation and management and psychogeriatric care.

A multidisciplinary management plan comprises a series of documented and agreed initiatives or treatments (specifying program goals, actions and timeframes) which has been established through multidisciplinary consultation and consultation with the patient and/or carers.

It is highly unlikely that, for care type changes involving subacute care types, more than one change in care type will take place within a 24-hour period. Changes involving subacute care types are unlikely to occur on the date of formal separation.

Patients who receive acute same-day intervention(s) during the course of a subacute episode of care do not change care type. Instead, procedure codes for the acute same-day intervention(s) and an additional diagnosis (if relevant) should be added to the record of the subacute episode of care.

Palliative care episodes can include grief and bereavement support for the family and carers of the patient where it is documented in the patient's medical record.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

See also Activity based funding: Admitted sub-acute and non-acute hospital care DSS 2013-2014 Independent Hospital Pricing Authority, Standard 11/10/2012

Supersedes Hospital service—care type, code N[N].N Health, Superseded 07/02/2013

Implementation in Data Set Specifications:

Admitted patient care NMDS 2013-14 Health, Superseded 11/04/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Admitted patient care NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Admitted patient mental health care NMDS 2013-14 Health, Standard 02/05/2013

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Admitted patient mental health care NMDS 2014-15 Health, Standardisation pending 18/07/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Admitted patient palliative care NMDS 2013-14 Health, Standard 02/05/2013

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Admitted patient palliative care NMDS 2014-15 Health, Standardisation pending 18/07/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Implementation in Indicators:

Used as numerator

National Healthcare Agreement: PI 09-Incidence of heart attacks, 2013 Health, Superseded 30/04/2014

National Healthcare Agreement: PI 09-Incidence of heart attacks, 2014 Health, Standard 30/04/2014

◊ Condition onset flag

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—condition onset flag, code N
Synonymous names:	COF
METeOR identifier:	496512
Registration status:	Health, Standard 07/02/2013
Definition:	A qualifier for each coded diagnosis to indicate the onset of the condition relative to the beginning of the episode of care, as represented by a code.
Data Element Concept:	Episode of admitted patient care—condition onset flag

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Condition with onset during the episode of admitted patient care
2	Condition not noted as arising during the episode of admitted patient care

Supplementary values:

9	Not reported

Collection and usage attributes

Guide for use:

COF 1 Condition with onset during the episode of admitted patient care

- a condition which arises during the episode of admitted patient care and would not have been present or suspected on admission.

Includes:

- A condition resulting from misadventure during surgical or medical care in the current episode of admitted patient care (e.g. accidental laceration during procedure, foreign body left in cavity, medication infusion error).
- An abnormal reaction to, or later complication of, surgical or medical care arising during the current episode of admitted patient care (e.g. postprocedural shock, disruption of wound, catheter associated urinary tract infection (UTI)).
- A condition newly arising during the episode of admitted patient care (e.g. pneumonia, rash, confusion, UTI, hypotension, electrolyte imbalance).
- A condition impacting on obstetric care arising after

admission, including complications or unsuccessful interventions of labour and delivery or prenatal/postpartum management (e.g. labour and delivery complicated by fetal heart rate anomalies, postpartum haemorrhage).

- For neonates, this also includes the condition(s) in the birth episode arising during the birth event (i.e. the labour and delivery process) (e.g. respiratory distress, jaundice, feeding problems, neonatal aspiration, conditions associated with birth trauma, newborn affected by delivery or intrauterine procedures).
- Disease status or administrative codes arising during the episode of admitted patient care (e.g. cancelled procedure, multi-resistant *Staphylococcus aureus* (MRSA)).

COF 2 Condition not noted as arising during the episode of admitted patient care

- a condition previously existing or suspected on admission such as the presenting problem, a comorbidity or chronic disease.

Includes:

- A condition that has not been documented at the time of admission, but clearly did not develop after admission (e.g. newly diagnosed diabetes mellitus, malignancy and morphology).
- A previously existing condition that is exacerbated during the current episode of admitted patient care (e.g. atrial fibrillation, unstable angina).
- A condition that is suspected at the time of admission and subsequently confirmed during the current episode of admitted patient care (e.g. pneumonia, acute myocardial infarction (AMI), stroke, unstable angina).
- A condition impacting on obstetric care arising prior to admission (e.g. venous complications, maternal disproportion).
- For neonates, this also includes the condition(s) in the birth episode arising before the labour and delivery process (e.g. prematurity, birth weight, talipes, clicking hip).
- Disease status or administrative codes not arising during the episode of admitted patient care (e.g. history of tobacco use, duration of pregnancy, colostomy status).
- Outcome of delivery (Z37) and place of birth (Z38) codes.

COF 9 Not reported

The condition onset flag could not be reported due to limitations of the data management system.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:

Assign the relevant COF value only to ICD-10-AM codes assigned in the principal diagnosis and additional diagnosis fields for the National Hospital Morbidity Database collection.

Sequencing of ICD-10-AM codes must comply with the Australian Coding Standards and therefore codes should not be re-sequenced in an attempt to list codes with the same COF values together.

The principal diagnosis code is always assigned COF 2. The exception to this is neonates in their admitted birth episode in that hospital where codes sequenced as the principal diagnosis may be assigned COF 1 if appropriate.

For neonates, where a condition in the admitted birth episode is determined to have arisen during the birth event (i.e. labour and delivery process), these conditions should be considered as arising during the episode of admitted patient care and assigned COF 1.

When a single ICD-10-AM code describes multiple concepts (i.e. a combination code) and any concept within that code meets the criteria of COF 1, assign COF 1.

When it is difficult to decide if a condition was present at the beginning of the episode of care or if it arose during the episode, assign a COF 2.

Explanatory notes:

The COF value assigned to external cause, place of occurrence and activity codes should match that of the corresponding injury or disease code. Injuries which occur during the admitted episode of care but not on the hospital grounds (e.g. hospital in the home (HITH)) should be assigned COF 1 as 'arising during the episode of admitted patient care'.

The COF value assigned to morphology codes should match that on the corresponding neoplasm code.

The COF value on Z codes related to the outcome of delivery on the mother's record (Z37), or the place of birth on the baby's record (Z38) should always be assigned COF 2.

The COF value on aetiology and manifestation (dagger and asterisk) codes should be appropriate to each condition and therefore the dagger and asterisk codes may be assigned different COF values.

An episode of admitted patient care includes all periods when the patient remains admitted and under the responsibility of the health care provider, including periods of authorised leave and HITH. Where diagnoses arising during this period meet the criteria for ACS 0002 *Additional diagnoses*, coders should apply the COF Guide for use instructions and assign COF 1 if appropriate. Unauthorised leave does not fall under the responsibility of the health care provider and conditions arising during this time should be assigned COF 2.

Where an admission has multiple admitted patient episode 'care type' changes (e.g. acute to rehabilitation), COF assignment should be relevant to each episode. A condition arising in an episode should be assigned COF 1. If care for that condition continues in subsequent episodes those conditions should be

assigned COF 2.

Collection methods: A condition onset flag should be recorded and coded upon completion of an episode of admitted patient care.

Comments: The condition onset flag is a means of differentiating those conditions which arise during, from those arising before, an admitted patient episode of care. Having this information will provide an insight into the kinds of conditions patients already have when entering hospital and those conditions that arise during the episode of admitted patient care. A better understanding of those conditions arising during the episode of admitted patient care may inform prevention strategies particularly in relation to complications of medical care.

The flag only indicates when the condition had onset, and cannot be used to indicate whether a condition was considered to be preventable.

Source and reference attributes

Origin: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Episode of admitted patient care—condition onset flag, code N Health, Superseded 07/02/2013

Implementation in Data Set Specifications: Admitted patient care NMDS 2013-14 Health, Superseded 11/04/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Admitted patient care NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Implementation in Indicators: **Used as numerator**
National Healthcare Agreement: PB g-Better health: the rate of *Staphylococcus aureus* (including MRSA) bacteraemia is no more than 2.0 per 10,000 occupied bed days for acute care public hospitals by 2011–12 in each state and territory, 2014 Health, Standard 30/04/2014

◊ Country identifier (person)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person (address)—country identifier, code (SACC 2011) NNNN
METeOR identifier:	459971
Registration status:	Community Services, Standard 28/02/2012 Health, Standard 28/02/2012 Tasmanian Health, Draft 25/03/2014
Definition:	The country component of the address of a person, as represented by a code.
Data Element Concept:	Person (address)—country identifier

Value domain attributes

Representational attributes

Classification scheme:	Standard Australian Classification of Countries 2011
Representation class:	Code
Data type:	Number
Format:	NNNN
Maximum character length:	4

Collection and usage attributes

Guide for use:	The Standard Australian Classification of Countries 2011 (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.

Data element attributes

Collection and usage attributes

Collection methods:	Collect the data at the 4-digit level.
Comments:	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).

Source and reference attributes

Reference documents:	Standard Australian Classification of Countries Edition 1, Catalogue number 1269.0, 2011, Canberra: Australian Bureau of Statistics

Relational attributes

Related metadata references:	Supersedes Person (address)—country identifier, code (SACC 2008) NNNN Community Services, Superseded 28/02/2012, Health, Superseded 28/02/2012
Implementation in Data Set Specifications:	Lung cancer (clinical) DSS Health, Standard 08/05/2014

▲ Date of first dental visit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Public dental waiting list episode—date of first visit, DDMMYYYY
Synonymous names:	Date of first dental treatment; Date of first dental assessment
METeOR identifier:	446601
Registration status:	Health, Standard 02/08/2012
Definition:	The date on which a person on a public dental waiting list attends their first dental visit, expressed as DDMMYYYY.
Context:	Public dental waiting times
Data Element Concept:	Public dental waiting list episode—date of first visit

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:

A public dental visit is defined as an appointment with a dental professional, as a result of being placed on the public dental waiting list. The appointment can be for assessment or treatment purposes.

Where a person attends multiple visits as part of a single waiting list episode, only the date of first attended visit is recorded.

Appointments which were scheduled but not attended by the person are not recorded.

Where a person is on an assessment waiting list, the visit is considered to be the assessment that results in removal from this list.

Where a person is on a general dental care or denture care waiting list, the visit is considered to be the treatment that results in removal from this list.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	See also Treatment commencement date Health, Standard

01/03/2005

Implementation in Data Set Specifications:

Public dental waiting times DSS 2012-13 Health, Superseded 09/11/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Conditional obligation:
This data item is recorded if the person has made a visit to a dental professional as a result of being placed on a public dental waiting list, regardless of setting.

Public dental waiting times NMDS 2013- Health, Standard 09/11/2012

Implementation start date: 01/07/2013

Conditional obligation:
This data item is recorded if the person has made a visit to a dental professional as a result of being placed on a public dental waiting list, regardless of setting.

◊ Diagnosis related group

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—diagnosis related group, code (AR-DRG v 6) ANNA
METeOR identifier:	391295
Registration status:	Health, Standard 30/06/2013 Tasmanian Health, Draft 23/07/2012
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, as represented by a code.
Data Element Concept:	Episode of admitted patient care—diagnosis related group

Value domain attributes

Representational attributes

Classification scheme:	Australian Refined Diagnosis Related Groups version 6
Representation class:	Code
Data type:	String
Format:	ANNA
Maximum character length:	4

Data element attributes

Collection and usage attributes

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.

Source and reference attributes

Origin:	National Centre for Classification in Health

Relational attributes

Related metadata references:	Is formed using Episode of admitted patient care—admission date, DDMMYYYY Health, Standard 01/03/2005, Tasmanian Health, Final 30/06/2014, National Health Performance Authority, Standard 07/11/2013 Has been superseded by Episode of admitted patient care—diagnosis related group, code (AR-DRG v 7) ANNA Health, Standardisation pending 13/03/2013 Supersedes Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA Health, Superseded 22/12/2009

Is formed using Episode of admitted patient care—intended length of hospital stay, code N Health, Standard 01/03/2005

See also Episode of admitted patient care—major diagnostic category, code (AR-DRG v 6) NN Health, Standard 30/06/2013

Is formed using Episode of admitted patient care—number of leave days, total N[NN] Health, Standard 01/03/2005

Is formed using Episode of admitted patient care—procedure, code (ACHI 7th edn) NNNNN-NN Health, Superseded 02/05/2013, National Health Performance Authority, Standard 07/11/2013

Is formed using Episode of admitted patient care—separation date, DDMMYYYY Health, Standard 01/03/2005, Tasmanian Health, Final 01/07/2014

Is formed using Episode of admitted patient care—separation mode, code N Health, Standard 01/03/2005

Is formed using Episode of care—additional diagnosis, code (ICD-10-AM 7th edn) ANN{.N[N]} Health, Superseded 02/05/2013, National Health Performance Authority, Standard 07/11/2013

Is formed using Episode of care—mental health legal status, code N Health, Superseded 07/12/2011

Is formed using Episode of care—principal diagnosis, code (ICD-10-AM 7th edn) ANN{.N[N]} Health, Superseded 02/05/2013, National Health Performance Authority, Standard 07/11/2013

Is formed using Person—date of birth, DDMMYYYY Community Services, Standard 25/08/2005, Housing assistance, Standard 20/06/2005, Health, Standard 04/05/2005, Early Childhood, Standard 21/05/2010, Homelessness, Standard 23/08/2010, Tasmanian Health, Final 30/06/2014, Independent Hospital Pricing Authority, Standard 01/11/2012, Indigenous, Endorsed 11/08/2014, National Health Performance Authority, Standard 07/11/2013

Is formed using Person—sex, code N Community Services, Standard 25/08/2005, Housing assistance, Standard 10/02/2006, Health, Standard 04/05/2005, Early Childhood, Standard 21/05/2010, Homelessness, Standard 23/08/2010, Independent Hospital Pricing Authority, Standard 01/11/2012, Indigenous, Endorsed 11/08/2014, National Health Performance Authority, Standard 07/11/2013

Is formed using Person—weight (measured), total grams NNNN Health, Standard 01/03/2005, Tasmanian Health, Final 01/07/2014

Implementation in Data Set Specifications:

Admitted patient care NMDS 2010-11 Health, Superseded 18/01/2011

Implementation start date: 01/07/2010

Implementation end date: 30/06/2011

Admitted patient care NMDS 2011-12 Health, Superseded 11/04/2012

Implementation start date: 01/07/2011

Implementation end date: 30/06/2012

Admitted patient care NMDS 2012-13 Health, Superseded 02/05/2013

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient mental health care NMDS 2010-11 Health, Superseded 18/01/2011

Implementation start date: 01/07/2010

Implementation end date: 30/06/2011

Admitted patient mental health care NMDS 2011-12 Health, Superseded 07/12/2011

Implementation start date: 01/07/2011

Implementation end date: 30/06/2012

Admitted patient mental health care NMDS 2012-13 Health, Superseded 02/05/2013

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

▲ Duration of continuous ventilatory support

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—duration of continuous ventilatory support, total hours NNNN
Synonymous names:	Duration of mechanical ventilation
METeOR identifier:	479010
Registration status:	Health, Standard 07/02/2013 Independent Hospital Pricing Authority, Standard 31/10/2012
Definition:	The total number of hours an admitted patient has spent on continuous ventilatory support.
Data Element Concept:	Episode of admitted patient care—duration of continuous ventilatory support

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NNNN
Maximum character length:	4
Unit of measure:	Hour (h)

Collection and usage attributes

Guide for use:	Total hours expressed as 0000, 0001, 0425 etc.

Data element attributes

Collection and usage attributes

Guide for use:

Continuous ventilatory support or invasive ventilation refers to the application of ventilation via an invasive artificial airway. For the purposes of this data element, invasive artificial airway is that provided via an endotracheal tube or a tracheostomy tube.

An endotracheal tube can be placed orally or nasally. It is usually employed prior to a surgically placed tracheostomy tube.

With prolonged ventilation, or when prolonged ventilation is expected, a tracheostomy tube is placed surgically.

Collection methods:

For the purposes of calculating the duration of continuous ventilatory support, begin calculation with one of the following:

- Initiation of continuous ventilatory support. For example, for patients with endotracheal intubation and subsequent initiation of continuous ventilatory support, begin counting at the time of intubation. Patients with a tracheostomy, begin counting at the point when continuous ventilatory support is begun; or
- Admission of a ventilated patient. For those patients admitted

with continuous ventilatory support, begin counting the duration at the time of the admission.

End the calculation with one of the following:

- Extubation (e.g. removal of endotracheal tube);
- Cessation of continuous ventilatory support after any period of weaning. For tracheostomy patients, the tracheal tube may not be withdrawn for days after discontinuation of continuous ventilatory support. Therefore, the duration would end with the cessation of continuous ventilatory support;
- Discharge, death of transfer of a patient on continuous ventilatory support; or
- Change of episode type.

Subsequent periods of continuous ventilatory support should be added together. For example, if a patient is on continuous ventilatory support on the first day of their admission, then again on the fourth day of their admission, the hours should be added together.

If there is a period of less than 1 hour between cessation and then restarting of ventilatory support, continue counting the duration. If there is removal and immediate replacement of airway devices, continue counting the duration.

Ventilatory support which is provided to a patient during surgery is associated with anaesthesia and is considered an integral part of the surgical procedure. Duration of continuous ventilatory support should not be counted if it is part of a surgical procedure, except in the following circumstances:

- Ventilatory support was performed for respiratory support prior to surgery and then continued during surgery and post surgery; or
- Ventilatory support was initiated during surgery, continues after surgery and for more than 24 hours post surgery.

Hours of ventilatory support should be reported as completed cumulative hours. For example, if the total duration of ventilatory support was 98 hours 45 minutes, report 98 hours.

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Reference documents: National Centre for Classification in Health 2010. Australian Coding Standards for ICD-10-AM (The International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification) and ACHI (The Australian Classification of Health Interventions) (7th edition). Sydney: National Centre for Classification in Health, Faculty of Health Sciences, The University of Sydney.

Relational attributes

Implementation in Data Set Specifications: Activity based funding: Admitted acute hospital care DSS 2013-2014 Independent Hospital Pricing Authority, Superseded 01/03/2013

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Conditional obligation:
Only required to be reported for episodes of care where the

admitted patient spent time in continuous ventilatory support.

Admitted acute care activity based funding DSS 2012-2013
Independent Hospital Pricing Authority, Superseded 31/10/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Conditional obligation:
Only required to be reported for episodes of care where the admitted patient spent time in continuous ventilatory support.

Admitted patient care NMDS 2013-14 Health, Superseded 11/04/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Conditional obligation:
This data element is only required to be reported for episodes of care where the admitted patient spent time in continuous ventilatory support.

Admitted patient care NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:
This data element is only required to be reported for episodes of care where the admitted patient spent time on continuous ventilatory support.

◊ ED additional diagnosis code

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Emergency department stay—additional diagnosis, code X[X(8)]
METeOR identifier:	497488
Registration status:	Health, Standard 07/02/2013 Independent Hospital Pricing Authority, Standard 31/10/2012
Definition:	The condition or complaint coexisting with the **emergency department** principal diagnosis during a patient's attendance to the emergency department, as represented by a code.
Data Element Concept:	Emergency department stay—additional diagnosis

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	X[X(8)]
Maximum character length:	9

Collection and usage attributes

Collection methods:

This value domain allows reporting of diagnosis using different code sets.

The code set can be represented by the following:

ICD-10-AM - 6th edition, 7th edition and 8th edition

International Statistical Classification of Diseases and Related Health Problems - 10th Revision - Australian Modification. ICD-10-AM is a classification of diseases and health related problems. ICD-10-AM diagnoses codes contain three core character codes with some expansion to four and five character codes. The format for ICD-10-AM diagnoses codes is ANN{.N[N]}

ICD-9-CM - 2nd edition

International Classification of Diseases - 9th Revision - Clinical Modification. ICD-9-CM is a classification of diseases. ICD-9-CM diagnoses codes contain four character codes with some expansion to five character codes. The format for ICD-9-CM diagnoses codes is NNN.N[N]

EDRS-SNOMED CT-AU

Systematized Nomenclature of Medicine - Clinical Terms - Australian version (Emergency Department Reference Set). SNOMED CT-AU is a clinical terminology which uses a structured vocabulary to describe the care and treatment of patients. There is a subset for emergency department care. The format for EDRS-SNOMED CT-AU diagnoses codes is NNNNNN[NNN]

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Data element attributes

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Relational attributes

Related metadata references: Supersedes Emergency department stay—additional diagnosis, code X(18) Independent Hospital Pricing Authority, Superseded 31/10/2012

See also Emergency department stay—diagnosis classification type, code N.N Health, Standard 07/02/2013, Independent Hospital Pricing Authority, Standard 31/10/2012

Implementation in Data Set Specifications: Activity based funding: Emergency department care DSS 2013-2014 Independent Hospital Pricing Authority, Superseded 01/03/2013

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Conditional obligation:

Only required to be reported when at least one additional diagnosis is present for the emergency department stay.

Non-admitted patient emergency department care DSS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:

This data element is only required to be reported when at least one additional diagnosis is present for the emergency department stay.

Non-admitted patient emergency department care NMDS 2013-14 Health, Superseded 11/04/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Conditional obligation:

This data element is only required to be reported when at least one additional diagnosis is present for the emergency department stay.

Non-admitted patient emergency department care NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:

This data element is only required to be reported when at least one additional diagnosis is present for the emergency department stay.

◊ ED diagnosis classification type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Emergency department stay—diagnosis classification type, code N.N
METeOR identifier:	497496
Registration status:	Health, Standard 07/02/2013 Independent Hospital Pricing Authority, Standard 31/10/2012
Definition:	The type of classification used for recording **emergency department** diagnosis, as represented by a code.
Data Element Concept:	Emergency department stay—diagnosis classification type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N.N
Maximum character length:	2

Permissible values:

Value	Meaning
1.0	SNOMED-CT-AU (EDRS)
2.0	ICD-9-CM, 2nd edition
3.6	ICD-10-AM, 6th edition
3.7	ICD-10-AM, 7th edition
3.8	ICD-10-AM, 8th edition

Supplementary values:

Value	Meaning
9.0	No diagnosis classification provided

Collection and usage attributes

Guide for use:

CODE 1.0 SNOMED-CT-AU (EDRS)

Systematized Nomenclature of Medicine - Clinical Terms - Australian version (Emergency Department Reference Set).

CODE 2.0 ICD-9-CM, 2nd edition

International Classification of Diseases - 9th Revision - Clinical Modification, 2nd edition.

CODE 3.6 ICD-10-AM, 6th edition

International Statistical Classification of Diseases and Related Health Problems - 10th Revision - Australian Modification, 6th edition.

CODE 3.7 ICD-10-AM, 7th edition

International Statistical Classification of Diseases and Related Health Problems - 10th Revision - Australian Modification, 7th edition.

CODE 3.8 ICD-10-AM, 8th edition

International Statistical Classification of Diseases and Related

Health Problems - 10th Revision - Australian Modification, 8th edition.

CODE 9.0 No diagnosis classification provided

No diagnosis classification type provided.

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Data element attributes

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Relational attributes

Related metadata references:

See also Emergency department stay—additional diagnosis, code X[X(8)] Health, Standard 07/02/2013, Independent Hospital Pricing Authority, Standard 31/10/2012

Supersedes Emergency department stay—diagnosis classification type, code N.N Independent Hospital Pricing Authority, Superseded 31/10/2012

See also Emergency department stay—principal diagnosis, code X[X(8)] Health, Standard 07/02/2013, Tasmanian Health, Final 02/07/2014, Independent Hospital Pricing Authority, Standard 31/10/2012

Implementation in Data Set Specifications:

Activity based funding: Emergency department care DSS 2013-2014 Independent Hospital Pricing Authority, Superseded 01/03/2013

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Conditional obligation:
Only required to be reported when a principal diagnosis and/or at least one additional diagnosis has been reported

Non-admitted patient emergency department care DSS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:
This data element is only required to be reported when a principal diagnosis and/or an additional diagnosis has been reported.

Non-admitted patient emergency department care NMDS 2013-14 Health, Superseded 11/04/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Conditional obligation:
This data element is only required to be reported when a principal diagnosis and/or an additional diagnosis has been

reported.

Non-admitted patient emergency department care NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:
This data element is only required to be reported when a principal diagnosis and/or an additional diagnosis has been reported.

◊ ED principal diagnosis code

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Emergency department stay—principal diagnosis, code X[X(8)]
METeOR identifier:	497490
Registration status:	Health, Standard 07/02/2013 Tasmanian Health, Final 02/07/2014 Independent Hospital Pricing Authority, Standard 31/10/2012
Definition:	The diagnosis established at the conclusion of the patient's attendance in an **emergency department** to be mainly responsible for occasioning the attendance following consideration of clinical assessment, as represented by a code.
Data Element Concept:	Emergency department stay—principal diagnosis

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	X[X(8)]
Maximum character length:	9

Collection and usage attributes

Collection methods:	This value domain allows reporting of diagnosis using different code sets. The code set can be represented by the following: ICD-10-AM - 6th edition, 7th edition and 8th edition International Statistical Classification of Diseases and Related Health Problems - 10th Revision - Australian Modification. ICD-10-AM is a classification of diseases and health related problems. ICD-10-AM diagnoses codes contain three core character codes with some expansion to four and five character codes. The format for ICD-10-AM diagnoses codes is ANN{.N[N]} ICD-9-CM - 2nd edition International Classification of Diseases - 9th Revision - Clinical Modification. ICD-9-CM is a classification of diseases. ICD-9-CM diagnoses codes contain four character codes with some expansion to five character codes. The format for ICD-9-CM diagnoses codes is NNN.N[N] EDRS-SNOMED CT-AU Systematized Nomenclature of Medicine - Clinical Terms - Australian version (Emergency Department Reference Set). SNOMED CT-AU is a clinical terminology which uses a structured vocabulary to describe the care and treatment of patients. There is a subset for emergency department care. The format for EDRS-SNOMED CT-AU diagnoses codes is

NNNNNN[NNN]

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Data element attributes

Collection and usage attributes

Guide for use:

An emergency department stay episode ends when either the patient is admitted, died or, if the patient is not to be admitted, when the patient is recorded as ready to leave the emergency department or when they are recorded as having left at their own risk.

The phrase 'at the conclusion' in the definition refers to evaluation of findings interpreted by the clinician available at the end of the emergency department episode. This may include information gained from the history of illness, any mental status evaluation, specialist consultations, physical examination, diagnostic tests or procedures, surgical procedures and pathological or radiological examination.

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Relational attributes

Related metadata references:

See also Emergency department stay—diagnosis classification type, code N.N Health, Standard 07/02/2013, Independent Hospital Pricing Authority, Standard 31/10/2012

Supersedes Emergency department stay—principal diagnosis, code X(18) Independent Hospital Pricing Authority, Superseded 31/10/2012

Implementation in Data Set Specifications:

Activity based funding: Emergency department care DSS 2013-2014 Independent Hospital Pricing Authority, Superseded 01/03/2013

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Conditional obligation:
The reporting of this data element is optional for those attendances where the value recorded for non-admitted patient emergency department service episode - episode end status is reported as:

- 4 - Did not wait to be attended by a health care professional;
- 5 - Left at own risk after being attended by a health care professional but before the non-admitted patient emergency department service episode was completed;
- 7 - Dead on arrival, emergency department clinician certified death.

Non-admitted patient emergency department care DSS 2014-15

Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:
The reporting of this data element is conditional for those attendances where the value recorded for *Non-admitted patient emergency department service episode – episode end status* is reported as either:

Code 4 - Did not wait to be attended by a health care professional;
Code 5 - Left at own risk after being attended by a health care professional but before the non-admitted patient emergency department service episode was completed; or
Code 7 - Dead on arrival, emergency department clinician certified the death of the patient.

Non-admitted patient emergency department care NMDS 2013-14 Health, Superseded 11/04/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Conditional obligation:

The reporting of this data element is conditional for those attendances where the value recorded for *Non-admitted patient emergency department service episode – episode end status* is reported as either:

Code 4 - Did not wait to be attended by a health care professional;
Code 5 - Left at own risk after being attended by a health care professional but before the non-admitted patient emergency department service episode was completed; or
Code 7 - Dead on arrival, emergency department clinician certified death.

Non-admitted patient emergency department care NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:
The reporting of this data element is conditional for those attendances where the value recorded for *Non-admitted patient emergency department service episode – episode end status* is reported as either:

Code 4 - Did not wait to be attended by a health care professional;
Code 5 - Left at own risk after being attended by a health care professional but before the non-admitted patient emergency department service episode was completed; or
Code 7 - Dead on arrival, emergency department clinician certified the death of the patient.

◊ External cause

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—external cause, code (ICD-10-AM 8th edn) ANN{.N[N]}
METeOR identifier:	514295
Registration status:	Health, Standard 02/05/2013
Definition:	The environmental event, circumstance or condition as the cause of injury, poisoning and other adverse effect, as represented by a code.
Data Element Concept:	Injury event—external cause

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 8th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:	This code must be used in conjunction with an injury or poisoning code and can be used with other disease codes. The external cause 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 V00 to Y84 must be accompanied by a place of occurrence code. External cause codes V00 to Y34 must be accompanied by an activity code.
Comments:	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. An extended activity code is being developed in consultation with the National Injury Surveillance Unit, Flinders University,

Adelaide.

Source and reference attributes

Origin: National Centre for Classification in Health
National Data Standards for Injury Surveillance Advisory Group

Relational attributes

Related metadata references: Supersedes Injury event—external cause, code (ICD-10-AM 7th edn) ANN{.N[N]} Health, Superseded 02/05/2013

Implementation in Data Set Specifications: Admitted patient care NMDS 2013-14 Health, Superseded 11/04/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

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

Admitted patient care NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

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

Injury surveillance DSS 2013- Health, Standard 02/05/2013

Implementation start date: 01/07/2013

DSS specific information:
As a minimum requirement, the external cause codes must be listed in the ICD-10-AM (3rd edition) classification.

◊ Full-time equivalent staff—mental health carer workers

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (mental health carer workers), average NNNN.NN
METeOR identifier:	450762
Registration status:	Health, Standard 07/02/2013
Definition:	The average number of full-time equivalent staff units paid for all **mental health carer workers** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (mental health carer workers)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	NNNN.NN
Maximum character length:	6
Unit of measure:	Full-time equivalent (FTE) staff
Unit of measure precision:	2

Data element attributes

Collection and usage attributes

Guide for use:

Mental health carer workers are persons employed (or engaged via contract) on a part-time or full-time basis, i.e. the person received a salary or contract fee on a regular basis. It does not refer to arrangements where the carer worker only received reimbursements of expenses or occasional sitting fees for attendance at meetings.

Mental health carer workers employed at the jurisdictional or regional level are considered in-scope and should be apportioned between all establishments, as deemed appropriate by the jurisdiction.

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment, full-time equivalent staff figures should be apportioned between all establishments to which services are provided on the basis of

hours paid for in each (salary costs should be apportioned on the same basis).

Comments: This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Establishment—full-time equivalent staff (paid) (carer consultants), average N[NNN{.N}] Health, Superseded 07/02/2013

Implementation in Data Set Specifications: Mental health establishments NMDS 2013-14 Health, Superseded 07/03/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Mental health establishments NMDS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Mental health establishments NMDS 2015-16 Health, Candidate 12/08/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

▲ Full-time equivalent staff—mental health consumer and carer workers

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (mental health consumer and carer workers), average NNNN.NN
METeOR identifier:	494044
Registration status:	Health, Standard 07/02/2013
Definition:	The average number of full-time equivalent staff units paid for all **mental health consumer workers** and **mental health carer workers** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (mental health consumer and carer workers)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	NNNN.NN
Maximum character length:	6
Unit of measure:	Full-time equivalent (FTE) staff
Unit of measure precision:	2

Data element attributes

Collection and usage attributes

Guide for use:

Includes **mental health consumer workers** and **mental health carer workers** employed by the organisation on a full-time or part-time salaried basis.

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

If under the relevant award of agreement a full-time nurse is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time nurse who works 64 hours is 0.8. If a full-time nurse under the same award is paid for a 100 hours for that fortnight (20 hours overtime), then the full-time equivalent is 100 divided by 80 = 1.25.

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same

basis).

Comments: This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

Mental health establishments NMDS 2013-14 Health, Superseded 07/03/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Mental health establishments NMDS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Mental health establishments NMDS 2015-16 Health, Candidate 12/08/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

◊ Full-time equivalent staff—mental health consumer workers

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—full-time equivalent staff (paid) (mental health consumer workers), average NNNN.NN
METeOR identifier:	450821
Registration status:	Health, Standard 07/02/2013
Definition:	The average number of full-time equivalent staff units paid for all **mental health consumer workers** within an establishment.
Data Element Concept:	Establishment—full-time equivalent staff (paid) (mental health consumer workers)

Value domain attributes

Representational attributes

Representation class:	Average
Data type:	Number
Format:	NNNN.NN
Maximum character length:	6
Unit of measure:	Full-time equivalent (FTE) staff
Unit of measure precision:	2

Data element attributes

Collection and usage attributes

Guide for use:

Mental health consumer workers are persons employed (or engaged via contract) on a part-time or full-time basis, i.e. the person received a salary or contract fee on a regular basis. It does not refer to arrangements where the consumer worker only received reimbursements of expenses or occasional sitting fees for attendance at meetings.

Mental health consumer workers employed at the jurisdictional or regional level are considered in-scope and should be apportioned between all establishments, as deemed appropriate by the jurisdiction.

The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.

Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing category. If the full-time equivalent for contract staff is not collected then salaries for those contract staff should be included in other recurrent expenditure data items.

Where staff provide services to more than one establishment, full-time equivalent staff figures should be apportioned between

all establishments to which services are provided on the basis of hours paid for in each (salary costs should be apportioned on the same basis).

Comments: This metadata item was amended during 1996-97. Until then, both average and end of year counts of full-time equivalent staff were included, and the end of year counts used as surrogates for the average counts if the latter were unavailable. The average count is more useful for accurate analysis of staffing inputs for establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes Establishment—full-time equivalent staff (paid) (consumer consultants), average N[NNN{.N}] Health, Superseded 07/02/2013

Implementation in Data Set Specifications: Mental health establishments NMDS 2013-14 Health, Superseded 07/03/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Mental health establishments NMDS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Mental health establishments NMDS 2015-16 Health, Candidate 12/08/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

◊ Healthcare associated *Staphylococcus aureus* bacteraemia clinical criteria

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient episode of *Staphylococcus aureus* bacteraemia—most probable healthcare associated *Staphylococcus aureus* bacteraemia clinical criteria, code N
METeOR identifier:	388928
Registration status:	Health, Standard 15/11/2012
Definition:	Most probable clinical criteria for a healthcare associated patient episode of *Staphylococcus aureus* bacteraemia (SAB) when the patient's first SAB positive blood culture was collected less than or equal to 48 hours after hospital admission, as represented by a code.
Data Element Concept:	Patient episode of *Staphylococcus aureus* bacteraemia—most probable healthcare associated *Staphylococcus aureus* bacteraemia clinical criteria

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	The patient episode of SAB is a complication of the presence of an indwelling medical device (e.g. intravascular line, haemodialysis vascular access, CSF shunt, urinary catheter)
2	The patient episode of SAB occurs within 30 days of a surgical procedure where the SAB is related to the surgical site
3	The patient episode of SAB was diagnosed within 48 hours of a related invasive instrumentation or incision
4	The patient episode of SAB is associated with neutropenia (Neutrophils: less than 1 x 10^9/L) contributed to by cytotoxic therapy

Supplementary values:

7	Not applicable
8	Unknown
9	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Australian Commission on Safety and Quality in Health Care (ACSQHC)

Origin: ACSQHC Healthcare Associated Infection Technical Working Group

Data element attributes

Collection and usage attributes

Guide for use:

A *Staphylococcus aureus* bacteraemia (SAB) will be considered to be a healthcare associated event if:

EITHER

- the patient's first SAB blood culture was collected more than 48 hours after hospital admission or less than 48 hours after discharge
- OR
- the patient's first SAB blood culture was collected less than or equal to 48 hours after hospital admission and one or more of the following key clinical criteria was met for the patient-episode of SAB.
    1. SAB is a complication of the presence of an indwelling medical device (e.g. intravascular line, haemodialysis vascular access, CSF shunt, urinary catheter)
    2. SAB occurs within 30 days of a surgical procedure where the SAB is related to the surgical site
    3. SAB was diagnosed within 48 hours of a related invasive instrumentation or incision
    4. SAB is associated with neutropenia (Neutrophils: less than 1 x 10^9/L) contributed to by cytotoxic therapy

The most probable healthcare associated clinical criteria should be selected.

If none of these criteria are met, then the SAB will be considered to be community-acquired for the purposes of surveillance.

Comments:

To identify whether SABs are community associated or healthcare associated, SABs should undergo a standard case review by a healthcare worker trained in Infectious Diseases/Infection Control.

Source and reference attributes

Submitting organisation: Australian Commission on Safety and Quality in Health Care (ACSQHC)

Origin: ACSQHC Healthcare Associated Infection Technical Working Group

Relational attributes

Implementation in Data Set Specifications: Surveillance of healthcare associated infection: *Staphylococcus aureus* bacteraemia DSS Health, Standard 15/11/2012

◊ Indicator procedure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—indicator procedure, code NN
METeOR identifier:	514033
Registration status:	Health, Standard 02/05/2013 National Health Performance Authority, Proposed 25/07/2013
Definition:	The indicator procedure for which an elective surgery patient is waiting, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode—indicator procedure

Value domain attributes

Representational attributes

Classification scheme:	Australian Classification of Health Interventions (ACHI) 8th edition
Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Permissible values:

Value	Meaning
01	Cataract extraction
02	Cholecystectomy
03	Coronary artery bypass graft
04	Cystoscopy
05	Haemorrhoidectomy
06	Hysterectomy
07	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
88	Other

Data element attributes

Collection and usage attributes

Guide for use:

The procedure terms are defined by the Australian Classification of Health Interventions (ACHI) codes which are listed in the Comments field 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.

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.

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.

The following is a list of ACHI (8th edition) codes comprising each indicator procedure category:

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] 42722-00 [201]

Cholecystectomy:

30443-00 [965] 30454-01 [965] 30455-00 [965]
30445-00 [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] 38500-05 [679]
38503-04 [678] 38503-05 [679] 90201-00 [679]
90201-01 [679] 90201-02 [679] 90201-03 [679]

Cystoscopy:

36812-00 [1089] 36812-01 [1089] 36836-00 [1098]

Haemorrhoidectomy:

32138-00 [941] 32132-00 [941] 32135-00 [941]
32135-01 [941] 32138-01 [941] 32138-02 [941]

Hysterectomy:

35653-00 [1268] 35653-01 [1268] 35661-00 [1268]
35670-00 [1268] 35667-00 [1268] 35664-00 [1268]
35657-00 [1269] 35756-00 [1269] 35673-02 [1269]
35753-02 [1269] 35667-01 [1269] 35664-01 [1269]
90450-00 [989] 90450-01 [989] 90450-02 [989]
35653-04 [1268] 90448-00 [1268] 90448-01 [1268]
90448-02 [1268]

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] 41635-01 [313]

Myringotomy:

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

Prostatectomy:

37203-00 [1165] 37203-02 [1165] 37207-00 [1166]
37207-01 [1166] 37203-05 [1166] 37203-06 [1166]
37200-03 [1167] 37200-04 [1167] 37209-00 [1167]
37200-05 [1167] 90407-00 [1168] 37201-00 [1165]
37203-03 [1166] 37203-04 [1166] 37224-00 [1162]
37224-01 [1162] 37209-01 [1166] 37210-01 [1166]
37211-01 [1166] 90408-00 [1162]

Septoplasty:

41671-02 [379] 41671-01 [379] 41671-03 [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] 49339-00 [1492] 49342-00 [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] 32507-00 [728] 32514-00 [737]

Source and reference attributes

Origin: National Health Data Committee

Reference documents:

National Casemix and Classification Centre (NCCC) 2012. The Australian Classification of Health Interventions (ACHI) – Eighth Edition - Tabular list of interventions and Alphabetic index of interventions. Wollongong: NCCC, Australian Health Services Research Institute, University of Wollongong.

ACHI 8th edition is available for purchase from the National Casemix and Classification Centre (NCCC). Please see the following link for product information: <http://nccc.uow.edu.au/icd10am-achi-acs/overview/achi/index.html>

Relational attributes

Related metadata references:

Supersedes Elective surgery waiting list episode—indicator procedure, code NN Health, Superseded 02/05/2013, National Health Performance Authority, Standard 28/05/2014

See also National Healthcare Agreement: PI 34-Waiting times for elective surgery, 2012 Health, Superseded 25/06/2013

Implementation in Data Set Specifications:

Elective surgery waiting times (census data) NMDS 2013- Health, Standard 02/05/2013

Implementation start date: 30/09/2013

Elective surgery waiting times (removals data) NMDS 2013-Health, Standard 02/05/2013

Implementation start date: 01/07/2013

Elective surgery waiting times cluster Health, Standard 11/04/2014

◊ Inter-hospital contracted patient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—inter-hospital contracted patient status, code N
METeOR identifier:	472024
Registration status:	Health, Standard 11/04/2012
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, as represented by a code.
Data Element Concept:	Episode of care—inter-hospital contracted patient status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
	Contracted (destination) hospital
1	Inter-hospital contracted patient from public sector hospital
2	Inter-hospital contracted patient from private sector hospital
	Contracting (originating) hospital
3	Inter-hospital contracted patient to public sector hospital
4	Inter-hospital contracted patient to private sector hospital
5	Not inter-hospital contracted

Supplementary values:

9	Not stated

Data element attributes

Collection and usage attributes

Guide for use:

Hospital activity provided under contract is to be reported by both the contracting (originating) hospital and by the contracted (destination) hospital, where the activity is recorded by both hospitals.

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.

This data element is designed to enable elimination of double counting of episodes of admitted patient care in national data compiled as per the APC NMDS. As such, contracted arrangements where the patient is only admitted to one hospital (i.e. contract type 4 where contract role=A) are not considered to be inter-hospital contracted care for the purposes of this data element. In contracted arrangements where the patient is admitted to both hospitals, provide data according to the guide for use below. In contracted arrangements where the patient is only admitted to one hospital, use code 5.

This data element item will be derived, using data elements Hospital—contract role, code A and Hospital—contract type, code N as follows.

If Contract role = B (Hospital B, that is, the provider of the hospital service; contracted hospital), and Contract type = 2, 3, 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.

If Contract role = A (Hospital A, that is, the hospital purchasing the activity; contracting hospital), and Contract type = 2, 3, or 5 (that is, the reporting hospital purchases the activity 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 3, if Hospital B is a public hospital or record a value of 4, if Hospital B is a private hospital.

Collection methods: All services provided at both the originating and destination hospitals should be recorded and reported by both hospitals. 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.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Episode of care—inter-hospital contracted patient status, code N Health, Superseded 11/04/2012

Is formed using Hospital—contract role, code A Health, Standard 01/03/2005

Is formed using Hospital—contract type, code N Health, Standard 01/03/2005

Implementation in Data Set Specifications: Admitted patient care NMDS 2012-13 Health, Superseded 02/05/2013

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient care NMDS 2013-14 Health, Superseded 11/04/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Admitted patient care NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

▲ Laboratory number

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory—organisation identifier, text X[X(39)]
METeOR identifier:	390779
Registration status:	Health, Standard 15/11/2012
Definition:	A unique identifier allocated to a laboratory, as represented by text.
Data Element Concept:	Laboratory—organisation identifier

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	X[X(39)]
Maximum character length:	40

Data element attributes

Source and reference attributes

Submitting organisation:	Australian Commission on Safety and Quality in Health Care (ACSQHC)
Origin:	ACSQHC Healthcare Associated Infection Technical Working Group

Relational attributes

Implementation in Data Set Specifications:	Surveillance of healthcare associated infection: Clostridium difficile infection DSS Health, Standardisation pending 23/07/2012 Surveillance of healthcare associated infection: *Staphylococcus aureus* bacteraemia DSS Health, Standard 15/11/2012

▲ Laboratory result identifier

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory—result identifier, text X[X(39)]
METeOR identifier:	428639
Registration status:	Health, Standard 15/11/2012
Definition:	Result identifier unique within a laboratory, as represented by text.
Data Element Concept:	Laboratory—result identifier

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	X[X(39)]
Maximum character length:	40

Data element attributes

Collection and usage attributes

Guide for use:	The assignment of an identifier to a result allows the linking of a result to a request within the laboratory. The laboratory result identifier will be derived from the pathology report and will be unique within the laboratory only.

Source and reference attributes

Submitting organisation:	Australian Commission on Safety and Quality in Health Care (ACSHQC)
Origin:	ACSQHC Healthcare Associated Infection Technical Working Group
Reference documents:	The National E-Health Transition Authority (NEHTA) Pathology Result Report Structured Document Template Version 1.0 2009

Relational attributes

Implementation in Data Set Specifications:	Surveillance of healthcare associated infection: Clostridium difficile infection DSS Health, Standardisation pending 23/07/2012 Surveillance of healthcare associated infection: *Staphylococcus aureus* bacteraemia DSS Health, Standard 15/11/2012

▲ Length of stay in intensive care unit

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—length of stay in intensive care unit, total hours NNNN
METeOR identifier:	471553
Registration status:	Health, Standard 07/02/2013 Independent Hospital Pricing Authority, Standard 31/10/2012
Definition:	The total number of hours an admitted patient has spent in an **intensive care unit**, expressed as a number.
Data Element Concept:	Episode of admitted patient care—length of stay in intensive care unit

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NNNN
Maximum character length:	4
Unit of measure:	Hour (h)

Collection and usage attributes

Guide for use:	Total hours expressed as 0000, 0001, 0425 etc.

Data element attributes

Collection and usage attributes

Guide for use:

The total number of hours is to be reported by public hospitals that have either an approved level 3 adult intensive care unit or an approved paediatric intensive care unit.

Adult intensive care unit, level 3

The unit must be capable of providing complex, multisystem life support for an indefinite period; be a tertiary referral centre for patients in need of intensive care services and have extensive backup laboratory and clinical service facilities to support the tertiary referral role. It must be capable of providing mechanical ventilation, extracorporeal renal support services and invasive cardiovascular monitoring for an indefinite period; or care of a similar nature.

Paediatric intensive care unit

The unit must be capable of providing complex, multisystem life support for an indefinite period; be a tertiary referral centre for children needing intensive care; and have extensive backup laboratory and clinical service facilities to support this tertiary role. It must be capable of providing mechanical ventilation, extracorporeal renal support services and invasive cardiovascular monitoring for an

indefinite period to infants and children less than 16 years of age; or care of a similar nature.

Collection methods:

For the purposes of calculating the length of stay in an intensive care unit, begin the calculation with the following:

- Arrival of the patient in the intensive care unit.

End the calculation with one of the following:

- Discharge, death or transfer of a patient from the intensive care unit; or
- Change of episode type.

Where an episode of admitted patient care involves more than one period spent in an intensive care unit, the total number of hours is to be reported for all periods during the episode of care.

The time spent in an operating theatre or in a coronary care unit is not counted.

Where there is a contracted service episode, Hospital A will report the total duration spent in the intensive care unit of Hospital B in addition to any length of time spent in Hospital A. Hospital B will only report the total time spent in the intensive care unit in Hospital B.

The total duration of hours reported should be rounded to the nearest hour. For example, if the total length of stay in the intensive care unit was 98 hours 45 minutes, report 99 hours.

If the duration of length of stay in an intensive care unit is equal to or greater than 9999 hours, report 9999 hours.

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Relational attributes

Implementation in Data Set Specifications:

Activity based funding: Admitted acute hospital care DSS 2013-2014
Independent Hospital Pricing Authority, Superseded 01/03/2013

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Conditional obligation:
Only required to be reported for episodes of care where the admitted patient spent time in an intensive care unit.

Admitted acute care activity based funding DSS 2012-2013
Independent Hospital Pricing Authority, Superseded 31/10/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Conditional obligation:
Only required to be reported for episodes of care where the admitted patient spent time in an intensive care unit.

Admitted patient care NMDS 2013-14 Health, Superseded 11/04/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Conditional obligation:
The data element is only required to be reported for episodes of care where the admitted patient spent time in an intensive care

unit.

Admitted patient care NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:
The data element is only required to be reported for episodes of care where the admitted patient spent time in an intensive care unit.

◊ Major diagnostic category

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—major diagnostic category, code (AR-DRG v 6) NN
METeOR identifier:	391298
Registration status:	Health, Standard 30/06/2013 Tasmanian Health, Draft 23/07/2012
Definition:	The category into which the patient's diagnosis and the associated Australian refined diagnosis related group (ARDG) falls, as represented by a code.
Data Element Concept:	Episode of admitted patient care—major diagnostic category

Value domain attributes

Representational attributes

Classification scheme:	Australian Refined Diagnosis Related Groups version 6
Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

Data element attributes

Collection and usage attributes

Comments:	This metadata item has been created to reflect the development of Australian refined diagnosis related groups (AR-DRGs) (as defined in the metadata item Episode of admitted patient care—diagnosis related group, code (AR-DRG v 6) ANNA) by the Commonwealth Department of Health and Ageing. Due to the modifications in the diagnosis related group logic for the AR-DRGs, 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.

Source and reference attributes

Submitting organisation:	Department of Health and Ageing, Acute and Co-ordinated Care Branch

Relational attributes

Related metadata references:	Is formed using Episode of admitted patient care—admission date, DDMMYYYY Health, Standard 01/03/2005, Tasmanian Health, Final 30/06/2014, National Health Performance

Authority, Standard 07/11/2013

See also Episode of admitted patient care—diagnosis related group, code (AR-DRG v 6) ANNA Health, Standard 30/06/2013, Tasmanian Health, Draft 23/07/2012

See also Episode of admitted patient care—diagnosis related group, code (AR-DRG v 6.0x) ANNA Tasmanian Health, Draft 23/07/2012

Is formed using Episode of admitted patient care—intended length of hospital stay, code N Health, Standard 01/03/2005

Has been superseded by Episode of admitted patient care—major diagnostic category, code (AR-DRG v 7) NN Health, Standardisation pending 30/06/2013

Supersedes Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN Health, Superseded 22/12/2009

Is formed using Episode of admitted patient care—number of leave days, total N[NN] Health, Standard 01/03/2005, Tasmanian Health, Draft 23/07/2012

Is formed using Episode of admitted patient care—procedure, code (ACHI 7th edn) NNNNN-NN Health, Superseded 02/05/2013, National Health Performance Authority, Standard 07/11/2013

Is formed using Episode of admitted patient care—separation date, DDMMYYYY Health, Standard 01/03/2005, Tasmanian Health, Final 01/07/2014

Is formed using Episode of admitted patient care—separation mode, code N Health, Standard 01/03/2005

Is formed using Episode of care—additional diagnosis, code (ICD-10-AM 7th edn) ANN{.N[N]} Health, Superseded 02/05/2013, National Health Performance Authority, Standard 07/11/2013

Is formed using Episode of care—mental health legal status, code N Health, Superseded 07/12/2011

Is formed using Episode of care—principal diagnosis, code (ICD-10-AM 7th edn) ANN{.N[N]} Health, Superseded 02/05/2013, National Health Performance Authority, Standard 07/11/2013

Is formed using Person—date of birth, DDMMYYYY Community Services, Standard 25/08/2005, Housing assistance, Standard 20/06/2005, Health, Standard 04/05/2005, Early Childhood, Standard 21/05/2010, Homelessness, Standard 23/08/2010, Tasmanian Health, Final 30/06/2014, Independent Hospital Pricing Authority, Standard 01/11/2012, Indigenous, Endorsed 11/08/2014, National Health Performance Authority, Standard 07/11/2013

Is formed using Person—sex, code N Community Services, Standard 25/08/2005, Housing assistance, Standard 10/02/2006, Health, Standard 04/05/2005, Early Childhood, Standard 21/05/2010, Homelessness, Standard 23/08/2010, Independent Hospital Pricing Authority, Standard 01/11/2012, Indigenous, Endorsed 11/08/2014, National Health Performance Authority, Standard 07/11/2013

Is formed using Person—weight (measured), total grams NNNN

Health, Standard 01/03/2005, Tasmanian Health, Final 01/07/2014

Implementation in Data Set Specifications:

Admitted patient care NMDS 2010-11 Health, Superseded 18/01/2011

Implementation start date: 01/07/2010

Implementation end date: 30/06/2011

Admitted patient care NMDS 2011-12 Health, Superseded 11/04/2012

Implementation start date: 01/07/2011

Implementation end date: 30/06/2012

Admitted patient care NMDS 2012-13 Health, Superseded 02/05/2013

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient mental health care NMDS 2010-11 Health, Superseded 18/01/2011

Implementation start date: 01/07/2010

Implementation end date: 30/06/2011

Admitted patient mental health care NMDS 2011-12 Health, Superseded 07/12/2011

Implementation start date: 01/07/2011

Implementation end date: 30/06/2012

Admitted patient mental health care NMDS 2012-13 Health, Superseded 02/05/2013

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

◊ Maternal medical conditions

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female (pregnant)—maternal medical condition, code (ICD-10-AM 8th edn) ANN{.N[N]}
METeOR identifier:	514275
Registration status:	Health, Standard 02/05/2013
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, as represented by a code.
Context:	Perinatal statistics
Data Element Concept:	Female (pregnant)—maternal medical condition

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 8th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Data element attributes

Collection and usage attributes

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.
Comments:	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.

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	Supersedes Female (pregnant)—maternal medical condition, code (ICD-10-AM 7th edn) ANN{.N[N]} Health, Superseded 02/05/2013

◊ Medicare eligibility status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—eligibility status, Medicare code N
METeOR identifier:	481841
Registration status:	Health, Standard 08/02/2012
Definition:	An indicator of a person's eligibility for Medicare at the time of the episode of care, as specified under the Commonwealth *Health Insurance Act 1973*, as represented by a code.
Context:	Admitted patient care: To facilitate analyses of hospital utilisation and policy relating to health care financing.
Data Element Concept:	Person—eligibility status

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Eligible
	2	Not eligible
Supplementary values:	9	Not stated/unknown

Data element attributes

Collection and usage attributes

Guide for use:

Eligible persons are

- Permanent residents of Australia
- Persons who have an application for permanent residence (not an aged parent visa), and have either:

- a spouse, parent or child who is an Australian citizen or permanent resident, OR

- authority from Department of Immigration and Multicultural and Indigenous Affairs to work

- Foreign spouses of Australian residents:

- must have an application for permanent residence, as above

- Asylum seekers who have been issued with valid temporary visas. The list of visas is subject to changes which may be applied by the Department of Immigration and Multicultural Affairs.
- American Fulbright scholars studying in Australia (but not

their dependents)

- Diplomats and their dependants from reciprocal health countries (excluding New Zealand and Norway) have full access to Medicare without the restrictions for American Fulbright scholars.

Reciprocal health care agreements

Residents of countries with whom Australia has Reciprocal health care agreements are also eligible under certain circumstances. Australia has Reciprocal Health Care Agreements with Ireland, Italy, Finland, Malta, the Netherlands, New Zealand, Norway, Sweden and the United Kingdom. These Agreements give visitors from these countries access to Medicare and the Pharmaceutical Benefits Scheme for the treatment of an illness or injury which occurs during their stay, and which requires treatment before returning home (that is, these Agreements cover immediately necessary medical treatment, elective treatment is not covered). The Agreements provide for free accommodation and treatment as public hospital services, but do not cover treatment as a private patient in any kind of hospital.

– The Agreements with Finland, Italy, Malta, the Netherlands, Norway, Sweden and the United Kingdom provide free care as a public patient in public hospitals, subsidised out-of-hospital medical treatment under Medicare, and subsidised medicines under the Pharmaceutical Benefits Scheme.

– The Agreements with New Zealand and Ireland provide free care as a public patient in public hospitals and subsidised medicines under the Pharmaceutical Benefits Scheme, but do not cover out-of-hospital medical treatment.

– Visitors from Italy and Malta are covered for a period of six months from the date of arrival in Australia only.

Eligible patients may elect to be treated as either a public or a private patient.

A newborn will usually take the Medicare eligibility status of the mother. However, the eligibility status of the father will be applied to the newborn if the baby is not eligible solely by virtue of the eligibility status of the mother.

For example, if the mother of a newborn is an ineligible person but the father is eligible for Medicare, then the newborn will be eligible for Medicare.

Not eligible/ineligible: means any person who is not Medicare eligible. Ineligible patients may not elect to be treated as a public patient.

Prisoners are ineligible for Medicare, under Section 19 (2) of the *Health Insurance Act 1973*.

Collection methods:

In practice, the primary method for ascertaining Medicare eligibility status is undertaken by the healthcare organisation sighting the patient's Medicare card.

Relational attributes

Related metadata references:

Supersedes Person—eligibility status, Medicare code N Health, Superseded 08/02/2012

Implementation in Data Set Specifications:

Admitted patient care NMDS 2012-13 Health, Superseded 02/05/2013

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Admitted patient care NMDS 2013-14 Health, Superseded 11/04/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Admitted patient care NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

◊ Mental health service contact date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Mental health service contact—service contact date, DDMMYYYY
METeOR identifier:	494343
Registration status:	Health, Standard 07/02/2013
Definition:	The date of each mental health service contact between a health service provider and patient/client, expressed as DDMMYYY.
Data Element Concept:	Mental health service contact—service contact date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Collection methods:	Requires services to record the date of each service contact, including the same date where multiple visits are made on one day (except where the visits may be regarded as a continuation of the one service contact). Where an individual patient/client participates in a group activity, a service contact date is recorded if the person's participation in the group activity results in a dated entry being made in the patient's/client's record. For collection from community based (ambulatory and non-residential) agencies.
Comments:	The service contact is required for clinical audit and other quality assurance purposes.

Relational attributes

Related metadata references:	Supersedes Mental health service contact—service contact date, DDMMYYYY Health, Superseded 07/02/2013
Implementation in Data Set Specifications:	Community mental health care NMDS 2013-14 Health, Superseded 07/03/2014 *Implementation start date:* 01/07/2013 *Implementation end date:* 30/06/2014 Community mental health care NMDS 2014-15 Health, Standard 07/03/2014 *Implementation start date:* 01/07/2014

Implementation end date: 30/06/2015

Community mental health care NMDS 2015-16 Health, Candidate 12/08/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

◊ Mental health service contact duration

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Mental health service contact—service duration, total minutes NNN
METeOR identifier:	494345
Registration status:	Health, Standard 07/02/2013
Definition:	The total time in minutes from the start to finish of a mental health service contact.
Data Element Concept:	Mental health service contact—mental health service duration

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NNN
Maximum character length:	3

Data element attributes

Collection and usage attributes

Guide for use:	For group sessions the time for the patient/client in the session is recorded for each patient/client, regardless of the number of patients/clients or third parties participating or the number of service providers providing the service. Writing up details of service contacts is not to be reported as part of the duration, except if during or contiguous with the period of patient/client or third party participation. Travel to or from the location at which the service is provided, for example to or from outreach facilities or private homes, is not to be reported as part of the duration of the service contact.
Comments:	Counting the duration for each patient/client in a group session means that this data element cannot be used to measure the duration of service contacts from the perspective of the service provider.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Mental health service contact—service contact duration, total minutes NNN Health, Superseded 07/02/2013
Implementation in Data Set	Community mental health care NMDS 2013-14 Health,

Specifications:

Superseded 07/03/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Community mental health care NMDS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Community mental health care NMDS 2015-16 Health, Candidate 12/08/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

◊ Mental health service contact—patient/client participation indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Mental health service contact—patient/client participation indicator, yes/no code N
METeOR identifier:	494341
Registration status:	Health, Standard 07/02/2013
Definition:	An indicator of whether the patient/client has participated in a service contact, as represented by a code.
Data Element Concept:	Mental health service contact—patient/client participation indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

Service contacts are not restricted to in-person communication but can include telephone, video link or other forms of direct communication.

CODE 1 Yes

This code is to be used for service contacts between a specialised mental health service provider and the patient/client in whose clinical record the service contact would normally warrant a dated entry, where the patient/client is participating.

CODE 2 No

This code is to be used for service contacts between a specialised mental health service provider and a third party(ies) where the patient/client, in whose clinical record the service contact would normally warrant a dated entry, is not participating.

Relational attributes

Related metadata references:	Supersedes Mental health service contact—patient/client participation indicator, yes/no code N Health, Superseded

	07/02/2013
Implementation in Data Set Specifications:	Community mental health care NMDS 2013-14 Health, Superseded 07/03/2014 *Implementation start date:* 01/07/2013 *Implementation end date:* 30/06/2014 Community mental health care NMDS 2014-15 Health, Standard 07/03/2014 *Implementation start date:* 01/07/2014 *Implementation end date:* 30/06/2015 Community mental health care NMDS 2015-16 Health, Candidate 12/08/2014 *Implementation start date:* 01/07/2015 *Implementation end date:* 30/06/2016

◊ Mental health service contact—session type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Mental health service contact—session type, code N
METeOR identifier:	494347
Registration status:	Health, Standard 07/02/2013
Definition:	Whether a service contact is provided for one or more patient(s)/client(s), as represented by a code.
Data Element Concept:	Mental health service contact—session type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Individual session
2	Group session

Data element attributes

Collection and usage attributes

Guide for use:

A service contact is regarded as an individual session where the service is provided for one patient/client with or without third party involvement.

A service contact is regarded as a group session where two or more patients/clients are participating in the service contact with or without third parties and the nature of the service would normally warrant dated entries in the clinical records of the patients/clients in question.

A service contact is also regarded as a group session where third parties for two or more patients/clients are participating in the service contact without the respective patients/clients and the nature of the service would normally warrant dated entries in the clinical records of the patients/clients in question.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Mental health service contact—session type, code N

Health, Superseded 07/02/2013

Implementation in Data Set Specifications:

Community mental health care NMDS 2013-14 Health, Superseded 07/03/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Community mental health care NMDS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Community mental health care NMDS 2015-16 Health, Candidate 12/08/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

◊ Number of clients receiving services

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—number of clients receiving services from an ambulatory mental health care service, total clients NNNNNN
METeOR identifier:	494391
Registration status:	Health, Standard 07/02/2013
Definition:	The total number of people or clients who received services provided by an **ambulatory mental health care service** unit.
Data Element Concept:	Specialised mental health service—number of clients receiving services from an ambulatory mental health care service

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NNNNNN
Maximum character length:	6
Unit of measure:	Person

Data element attributes

Collection and usage attributes

Guide for use:	The total number of clients is reported by ambulatory mental health care service units to the Mental health establishments NMDS. The total should be a count of uniquely identifiable individuals at the service unit level, regardless of the registration status of the client, who are reported to the Community mental health care NMDS.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Specialised mental health service—number of clients receiving services, total NNNNNN Health, Superseded 07/02/2013
Implementation in Data Set Specifications:	Mental health establishments NMDS 2013-14 Health, Superseded 07/03/2014 *Implementation start date:* 01/07/2013 *Implementation end date:* 30/06/2014 Mental health establishments NMDS 2014-15 Health, Standard

07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Mental health establishments NMDS 2015-16 Health, Candidate 12/08/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

▲ Number of group session non-admitted patient service events

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of group session non-admitted patient service events, total service events N[NNNNNN]
METeOR identifier:	497980
Registration status:	Health, Standard 07/02/2013 Independent Hospital Pricing Authority, Standard 31/10/2012
Definition:	The total number of non-admitted patient service events provided as group sessions to non-admitted patients in an establishment.
Data Element Concept:	Establishment—Number of group session non-admitted patient service events

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Service event

Data element attributes

Collection and usage attributes

Guide for use:	Each patient attending a group session is counted as a non-admitted patient service event, providing that the session included the provision of therapeutic/clinical advice for each patient and that this was recorded using a dated entry in each patient's medical record. Family members are only counted as attending a group session if they are participating in the non-admitted patient service event as a patient in their own right. Each patient attending a group session is counted as one non-admitted patient service event, regardless of the number of health care providers present.

Relational attributes

Related metadata references:	Has been superseded by Establishment—number of group session non-admitted patient service events, total service events N[NNNNNN] Health, Candidate 29/08/2014
Implementation in Data Set Specifications:	Activity based funding: Non-admitted patient care aggregate DSS 2013-2014 Independent Hospital Pricing Authority,

Superseded 01/03/2013

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Non-admitted patient care aggregate NMDS 2013-14 Health, Superseded 11/04/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Non-admitted patient care hospital aggregate NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Non-admitted patient care Local Hospital Network aggregate DSS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

▲ Number of individual session non-admitted patient service events

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of individual session non-admitted patient service events, total service events N[NNNNNN]
METeOR identifier:	498005
Registration status:	Health, Standard 07/02/2013 Independent Hospital Pricing Authority, Standard 31/10/2012
Definition:	The total number of non-admitted patient service events provided as individual sessions to non-admitted patients in an establishment.
Data Element Concept:	Establishment—number of individual session non-admitted patient service events

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNNNN]
Maximum character length:	7
Unit of measure:	Service event

Data element attributes

Collection and usage attributes

Guide for use:

A non-admitted service which meets the criteria of a non-admitted patient service event should be counted only once, regardless of the number of health care providers present.

An individual non-admitted patient service event is one where care was delivered to one patient by one or more health care providers. For example:

- A health care provider working one on one with several different patients in the same space over the same period of time, but each patient is following their own personalised program (such as several patients scheduled to use the physiotherapy gym at once).
- Multiple family members and a patient meeting with the health care provider to discuss the one patient only.

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Relational attributes

Related metadata references:

Has been superseded by Establishment—number of individual session non-admitted patient service events, total service events N[NNNNNN] Health, Candidate 29/08/2014

Implementation in Data Set Specifications:

Activity based funding: Non-admitted patient care aggregate DSS 2013-2014 Independent Hospital Pricing Authority, Superseded 01/03/2013

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Non-admitted patient care aggregate NMDS 2013-14 Health, Superseded 11/04/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Non-admitted patient care hospital aggregate NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Non-admitted patient care Local Hospital Network aggregate DSS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

◊ Number of service contacts

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—number of service contacts provided to clients by an ambulatory mental health care service, total contacts NNNNNN
METeOR identifier:	494401
Registration status:	Health, Standard 07/02/2013
Definition:	The total number of service contacts provided to individual patients or clients by an **ambulatory mental health care service**.
Data Element Concept:	Specialised mental health service—number of service contacts provided to clients by an ambulatory mental health care service

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	NNNNNN
Maximum character length:	6
Unit of measure:	Service contact

Data element attributes

Collection and usage attributes

Guide for use:	The total number of mental health service contacts is reported by ambulatory mental health care service units to the Mental Health Establishments NMDS. The total should be a count of contacts at the service unit level, regardless of the registration status of the client. Each patient or client attending a group contact should be counted individually. For example, ten consumers in a group contact equates to ten contacts.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	See also Mental health service contact Health, Superseded 07/02/2013 See also Mental health service contact Health, Standard 07/02/2013 Supersedes Specialised mental health service—number of service contacts, total NNNNNN Health, Superseded 07/02/2013
Implementation in Data Set	Mental health establishments NMDS 2013-14 Health, Superseded

Specifications:

07/03/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Mental health establishments NMDS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Mental health establishments NMDS 2015-16 Health, Candidate 12/08/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

▲ Offer of dental care date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Public dental waiting list episode—date of offer of dental care, DDMMYYYY
Synonymous names:	Date of offer of dental care; Date of dental care offer
METeOR identifier:	428965
Registration status:	Health, Standard 02/08/2012
Definition:	The date on which a formal offer of dental care is made to a person on a public dental waiting list, expressed as DDMMYYYY.
Context:	Public dental waiting times.
Data Element Concept:	Public dental waiting list episode—date of offer of dental care

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:

A dental care episode includes assessment if the person is on a waiting list for assessment, or treatment if the person is on a waiting list for general care and/or denture care.

Where the offer of dental care is made by letter, the date of offer is the date of the letter.

Where the offer of dental care is made by phone call, the date of offer is the date of the call.

Where a person has received multiple offers of dental care as part of a single waiting list episode, only the first offer of care is recorded.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Public dental waiting times DSS 2012-13 Health, Superseded 09/11/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Conditional obligation:
This data item is recorded if an offer of care has been made.

Public dental waiting times NMDS 2013- Health, Standard 09/11/2012

Implementation start date: 01/07/2013

Conditional obligation:
This data item is recorded if an offer of care has been made.

▲ Patient episodes of healthcare associated *Staphylococcus aureus* bacteraemia

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—number of patient episodes of healthcare associated *Staphylococcus aureus* bacteraemia, total episodes N[NNNN]
Synonymous names:	Patient episodes of healthcare associated SAB
METeOR identifier:	428594
Registration status:	Health, Standard 15/11/2012
Definition:	The total number of patient episodes of healthcare associated *Staphylococcus aureus* bacteraemia (SAB) occurring within the organisation during a specified reference period.
Data Element Concept:	Establishment—number of patient episodes of healthcare associated *Staphylococcus aureus* bacteraemia

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNN]
Maximum character length:	5

Data element attributes

Collection and usage attributes

Guide for use:

Patient episodes of healthcare associated *Staphylococcus aureus* bacteraemia (SAB) may be counted for

- an individual establishment i.e. the sum of the number of patient episodes of healthcare associated SAB within the establishment; and/or
- a jurisdiction (i.e. state/territory) i.e. the sum of the number of patient episodes of healthcare associated SAB within establishments within the jurisdiction.

SAB rates will be calculated for each healthcare facility and jurisdiction as follows:

10,000 x (Numerator ÷ Denominator)

Numerator: Patient episodes of Healthcare associated SAB

Denominator: Number of patient days

As with all hospital-based infection surveillance, the responsibility for collection, analysis and reporting generally rests with hospital infection control teams. In many states, jurisdictional surveillance units provide support for these activities for at least some hospitals, and relevant manuals and

material from such units should be used where appropriate.

Source and reference attributes

Submitting organisation:	Australian Commission on Safety and Quality in Health Care (ACSQHC)
Origin:	ACSQHC Healthcare Associated Infection Technical Working Group

Relational attributes

Related metadata references:	See also Establishment—number of patient days under infection surveillance monitoring, total days N[N(7)] National Health Performance Authority, Standard 13/03/2014 See also Establishment—number of patient days, total N[N(7)] Health, Standard 01/03/2005, National Health Performance Authority, Standard 13/03/2014
Implementation in Data Set Specifications:	Surveillance of healthcare associated infection: *Staphylococcus aureus* bacteraemia DSS Health, Standard 15/11/2012

◊ Patient listing status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective surgery waiting list episode—patient listing status, readiness for care code N
METeOR identifier:	471698
Registration status:	Health, Standard 02/05/2013
Definition:	An indicator of the person's readiness to begin the process leading directly to being admitted to hospital for the awaited procedure, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode—patient listing status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Ready for care
2	Not ready for care

Data element attributes

Collection and usage attributes

Guide for use:

A patient may be 'ready for care' or 'not ready for care'. Ready for care patients are those who are prepared to be admitted to hospital or to begin the process leading directly to admission. These could include investigations/procedures done on an outpatient basis, such as autologous blood collection, pre-operative diagnostic imaging or blood tests. Not ready for care patients are those who are not in a position to be admitted to hospital. These patients are either:

- staged patients whose medical condition will not require or be amenable to surgery until some future date; for example, a patient who has had internal fixation of a fractured bone and who will require removal of the fixation device after a suitable time; or
- deferred patients who for personal reasons are not yet prepared to be admitted to hospital; for example, patients with work or other commitments which preclude their being admitted to hospital for a time.

Not ready for care patients could be termed staged and deferred waiting list patients, although currently health authorities may

use different terms for the same concepts.

Staged and deferred patients should not be confused with patients whose operation is postponed for reasons other than their own unavailability, for example; surgeon unavailable, operating theatre time unavailable owing to emergency workload. These patients are still 'ready for care'.

Periods when patients are not ready for care should be excluded in determining 'Waiting time (at removal)' and 'Waiting time (at a census date)'.

Comments:

The dates when a patient listing status changes need to be recorded. A patient's classification may change if he or she is examined by a clinician during the waiting period, i.e. undergoes **clinical review**. The need for clinical review varies with the patient's condition and is therefore at the discretion of the treating clinician. The waiting list information system should be able to record dates when the classification is changed (metadata item Category reassignment date).

At the Waiting Times Working Group meeting on 9 September 1996, it was agreed to separate the metadata items Patient listing status, readiness for care and Clinical urgency as the combination of these items had led to confusion.

Source and reference attributes

Submitting organisation:

Hospital Access Program Waiting Lists Working Group

Waiting Times Working Group

Origin:

National Health Data Committee

Relational attributes

Related metadata references:

Supersedes Patient listing status, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.7 KB)

Implementation in Data Set Specifications:

Elective surgery waiting times (census data) NMDS 2012-13 Health, Superseded 02/05/2013

Implementation start date: 30/09/2012

Implementation end date: 30/06/2013

Elective surgery waiting times (census data) NMDS 2013- Health, Standard 02/05/2013

Implementation start date: 30/09/2013

▲ Person identifier flag

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—unique identifier used indicator, yes/no code N
METeOR identifier:	493279
Registration status:	Community Services, Standard 19/09/2013 Health, Standard 07/02/2013
Definition:	An indicator of whether a person identifier is for a uniquely identifiable person within an establishment or agency, as represented by a code.
Data Element Concept:	Person—unique identifier used indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

CODE 1 Yes

This code means the patient identifier is a number for a uniquely identified person.

CODE 2 No

This code means the patient identifier is a number for a non-uniquely identifiable person.

The assignment of *Person identifier* to a uniquely identifiable individual is important for the Community Mental Health Care (CMHC) NMDS to permit the determination of the number of clients receiving services within a jurisdiction. The ability of jurisdictions to generate unique identifiers varies, as described in the data quality statement for the CMHC NMDS.

Relational attributes

Related metadata references: See also Person—person identifier, XXXXXX[X(14)] Community Services, Standard 25/08/2005, Health, Standard 04/05/2005, Early Childhood, Standard 08/04/2013, Independent Hospital Pricing Authority, Standard 01/11/2012, Indigenous, Endorsed 11/08/2014, National Health Performance Authority, Standard

	28/05/2014
Implementation in Data Set Specifications:	Community mental health care NMDS 2013-14 Health, Superseded 07/03/2014 *Implementation start date:* 01/07/2013 *Implementation end date:* 30/06/2014 Community mental health care NMDS 2014-15 Health, Standard 07/03/2014 *Implementation start date:* 01/07/2014 *Implementation end date:* 30/06/2015 Community mental health care NMDS 2015-16 Health, Candidate 12/08/2014 *Implementation start date:* 01/07/2015 *Implementation end date:* 30/06/2016

◊ Place of occurrence of external cause of injury (ICD-10-AM)

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Injury event—place of occurrence, code (ICD-10-AM 8th edn) ANN{.N[N]}
METeOR identifier:	514302
Registration status:	Health, Standard 02/05/2013
Definition:	The place where the external cause of injury, poisoning or adverse effect occurred, as represented by a code.
Data Element Concept:	Injury event—place of occurrence

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 8th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:	Admitted patient: External cause codes in the range V00 to Y89 must be accompanied by a place of occurrence code. External cause codes V00 to Y34 must be accompanied by an activity code.
Comments:	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.

Source and reference attributes

Origin:	National Centre for Classification in Health AIHW National Injury Surveillance Unit National Data Standards for Injury Surveillance Advisory Group

Relational attributes

Related metadata references:	Supersedes Injury event—place of occurrence, code (ICD-10-AM 7th edn) ANN{.N[N]} Health, Superseded 02/05/2013

Implementation in Data Set Specifications:

Admitted patient care NMDS 2013-14 Health, Superseded 11/04/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

DSS specific information:
To be used with ICD-10-AM external cause codes.

Admitted patient care NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

DSS specific information:
To be used with ICD-10-AM external cause codes.

Injury surveillance DSS 2013- Health, Standard 02/05/2013

Implementation start date: 01/07/2013

◊ Postpartum perineal status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Female (mother)—postpartum perineal status, code N[N]
METeOR identifier:	423659
Registration status:	Health, Standard 07/02/2013
Definition:	The state of the perineum following birth, as represented by a code.
Context:	Perinatal statistics
Data Element Concept:	Female (mother)—postpartum perineal status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
1	Intact
2	1st degree laceration/vaginal graze
3	2nd degree laceration
4	3rd degree laceration
5	Episiotomy
7	4th degree laceration
88	Other perineal laceration, rupture or tear

Supplementary values:

99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 2 1st degree laceration/vaginal graze

Graze, laceration, rupture or tear of the perineal skin during delivery that may be considered to be slight or that involves one or more of the following structures:

- fourchette
- labia
- vagina
- vulva

CODE 3 2nd degree laceration

Perineal laceration, rupture or tear as in Code 2 occurring during delivery, also involving:

- pelvic floor
- perineal muscles

- vaginal muscles

Excludes laceration involving the anal sphincter.

CODE 4 3rd degree laceration

Perineal laceration, rupture or tear as in Code 3 occurring during delivery, also involving:

- anal sphincter
- rectovaginal septum
- sphincter not otherwise specified (NOS)

Excludes laceration involving the anal or rectal mucosa.

CODE 7 4th degree laceration

Perineal laceration, rupture or tear as in Code 4 occurring during delivery, also involving:

- anal mucosa
- rectal mucosa

CODE 88 Other perineal laceration, rupture or tear

May include haematoma or unspecified perineal tear.

Comments:

If a laceration occurred during delivery and an episiotomy was performed, both the degree of laceration and the episiotomy should be recorded. If an episiotomy is performed, the perineum cannot be intact.

While 4th degree laceration is more severe than an episiotomy, this category has not been placed in order of clinical significance within the value domain. Instead, the category has been added to the value domain as a new code rather than modifying the order of the existing permissible values. This approach is consistent with established practice in classifications, wherein a new value domain identifier (or code number) is assigned to any new value meaning that occurs, rather than assigning this new value domain meaning to an existing value domain identifier.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Origin: National Centre for Classification in Health (NCCH) 2010. The International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) – Seventh Edition - Tabular list of diseases and Alphabetic index of diseases. Sydney: NCCH, Faculty of Health Sciences, The University of Sydney.

Data element attributes

Collection and usage attributes

Guide for use: Multiple entries of permissible values are allowed.

Comments: 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 obstetric intervention.

Relational attributes

Related metadata references:

Supersedes Female (mother)—postpartum perineal status, code N Health, Superseded 07/02/2013

Implementation in Data Set Specifications:

Perinatal NMDS 2013-14 Health, Superseded 07/03/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Perinatal NMDS 2014- Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

◊ Principal diagnosis—episode of care

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of care—principal diagnosis, code (ICD-10-AM 8th edn) ANN{.N[N]}
METeOR identifier:	514273
Registration status:	Health, Standard 02/02/2013 Tasmanian Health, Final 01/07/2014 National Health Performance Authority, Proposed 27/11/2013
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, as represented by a code.
Data Element Concept:	Episode of care—principal diagnosis

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 8th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Data element attributes

Collection and usage attributes

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. 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 an error DRG in the Australian Refined Diagnosis Related Groups. 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 admitted patient care or episode of residential care or attendance at a health care establishment. The principal diagnosis is derived from and must be substantiated by clinical documentation.

Comments: The principal diagnosis is one of the most valuable health data elements. It is used for epidemiological research, casemix studies and planning purposes.

Source and reference attributes

Origin: National Centre for Classification in Health

National Data Standard for Injury Surveillance Advisory Group

Relational attributes

Related metadata references: Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v 7) ANNA Health, Standardisation pending 13/03/2013

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v 7) NN Health, Standardisation pending 30/06/2013

Supersedes Episode of care—principal diagnosis, code (ICD-10-AM 7th edn) ANN{.N[N]} Health, Superseded 02/05/2013, National Health Performance Authority, Standard 07/11/2013

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS 2013- Health, Standard 02/05/2013

Implementation start date: 01/07/2013

Admitted patient care NMDS 2013-14 Health, Superseded 11/04/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Conditional obligation:
The principal diagnosis is a major determinant in the classification of Australian Refined Diagnosis Related Groups and Major Diagnostic Categories.

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.

Admitted patient care NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:
The principal diagnosis is a major determinant in the classification of Australian Refined Diagnosis Related Groups and Major Diagnostic Categories.

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.

Admitted patient mental health care NMDS 2013-14 Health, Standard 02/05/2013

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

DSS specific information:
Effective for collection from 01/07/2006

Admitted patient mental health care NMDS 2014-15 Health, Standardisation pending 18/07/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

DSS specific information:
Effective for collection from 01/07/2006

Admitted patient palliative care NMDS 2013-14 Health, Standard 02/05/2013

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Admitted patient palliative care NMDS 2014-15 Health, Standardisation pending 18/07/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Community mental health care NMDS 2013-14 Health, Superseded 07/03/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

DSS specific information:
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.

Community mental health care NMDS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

DSS specific information:
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.

Community mental health care NMDS 2015-16 Health, Candidate 12/08/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

DSS specific information:
Codes can be used either 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.

Residential mental health care NMDS 2013-14 Health, Superseded 07/03/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

DSS specific information:
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 2002.

The principal diagnosis should be recorded and coded upon the end of an episode of residential care (i.e. annually for continuing residential care).

Residential mental health care NMDS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

DSS specific information:
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 2002.

The principal diagnosis should be recorded and coded upon the end of an episode of residential care (i.e. annually for continuing residential care).

Residential mental health care NMDS 2015-16 Health, Candidate 12/08/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

DSS specific information:
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 2002.

The principal diagnosis should be recorded and coded upon the end of an episode of residential care (i.e. annually for continuing residential care).

◊ Principal diagnosis—patient

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient—principal diagnosis, (ICD-10-AM 8th edn) ANN{.N[N]}
METeOR identifier:	514304
Registration status:	Health, Standard 02/05/2013
Definition:	The diagnosis established after study to be chiefly responsible for occasioning a patient's service event or episode, as represented by a code.
Data Element Concept:	Patient—principal diagnosis

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 8th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Data element attributes

Relational attributes

Related metadata references:	Supersedes Patient—principal diagnosis, (ICD-10-AM 7th edn) ANN{.N[N]} Health, Superseded 02/05/2013
Implementation in Data Set Specifications:	Radiotherapy waiting times DSS 2013-15 Health, Standardisation pending 29/04/2014 *Implementation start date:* 01/07/2013 *Implementation end date:* 30/06/2015 Radiotherapy waiting times NMDS 2015- Health, Standardisation pending 16/06/2014 *Implementation start date:* 01/07/2015

◊ Procedure

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Episode of admitted patient care—procedure, code (ACHI 8th edn) NNNNN-NN
METeOR identifier:	514040
Registration status:	Health, Standard 02/05/2013 Tasmanian Health, Final 01/07/2014 National Health Performance Authority, Proposed 27/11/2013
Definition:	A **clinical intervention** represented by a code 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.
Data Element Concept:	Episode of admitted patient care—procedure

Value domain attributes

Representational attributes

Classification scheme:	Australian Classification of Health Interventions (ACHI) 8th edition
Representation class:	Code
Data type:	Number
Format:	NNNNN-NN
Maximum character length:	7

Data element attributes

Collection and usage attributes

Collection methods:	Record and code all procedures undertaken during the episode of care in accordance with the ACHI (8th edition). Procedures are derived from and must be substantiated by clinical documentation.
Comments:	The National Centre for Classification in Health advises the National Health Information Standards and Statistics Committee of relevant changes to the ACHI.

Source and reference attributes

Origin:	National Centre for Classification in Health National Health Information Standards and Statistics Committee

Relational attributes

Related metadata references:

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v 7) ANNA Health, Standardisation pending 13/03/2013

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v 7) NN Health, Standardisation pending 30/06/2013

Supersedes Episode of admitted patient care—procedure, code (ACHI 7th edn) NNNNN-NN Health, Superseded 02/05/2013, National Health Performance Authority, Standard 07/11/2013

Implementation in Data Set Specifications:

Admitted patient care NMDS 2013-14 Health, Superseded 11/04/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

DSS specific information:

As a minimum requirement procedure codes must be valid codes from the Australian Classification of Health Interventions (ACHI) 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.

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.

Record all procedures undertaken during an episode of care in accordance with the ACHI (8th edition) 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.

Admitted patient care NMDS 2014-15 Health, Standard 11/04/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

DSS specific information:

As a minimum requirement procedure codes must be valid codes from the Australian Classification of Health Interventions (ACHI) 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.

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.

Record all procedures undertaken during an episode of care in accordance with the ACHI (8th edition) 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.

▲ Public dental listing date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Public dental waiting list episode—listing date for care, DDMMYYYY
Synonymous names:	Date placed on public dental waiting list
METeOR identifier:	428485
Registration status:	Health, Standard 02/08/2012
Definition:	The date a person is placed on a public dental waiting list, expressed as DDMMYYYY.
Context:	Public dental waiting times
Data Element Concept:	Public dental waiting list episode—listing date for care

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	The listing date for care is the date on which the person is placed on the dental waiting list by the public dental service.
Collection methods:	Data obtained from service records.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:	Public dental waiting times DSS 2012-13 Health, Superseded 09/11/2012 *Implementation start date:* 01/07/2012 *Implementation end date:* 30/06/2013 Public dental waiting times NMDS 2013- Health, Standard 09/11/2012 *Implementation start date:* 01/07/2013

▲ Public dental waiting list type

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Public dental waiting list episode—waiting list type, code N
METeOR identifier:	429615
Registration status:	Health, Standard 02/08/2012
Definition:	The type of public dental waiting list upon which a person is placed, as represented by a code.
Context:	Public dental waiting times
Data Element Concept:	Public dental waiting list episode—waiting list type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	General dental care
2	Denture care
3	Assessment

Supplementary values:

9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 General dental care

The person is on a waiting list to receive general dental care. 'General dental care' is any examination and treatment relating to natural teeth and soft tissue resulting in a person being dentally fit, excluding specialist services and denture treatment.

CODE 2 Denture care

The person is on a waiting list to receive denture care. 'Denture care' is provision of full or partial dentures or other dental prosthetic devices for the full or partial restoration and/or maintenance of oral health, function and appearance.

CODE 3 Assessment

The person is on a waiting list for an assessment. An 'assessment' is a consultation and examination to determine future treatment.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Victorian Department of Human Services - Public dental non-urgent care wait list policy

Reference documents: Victorian Department of Human Services 2011. Public dental non-urgent care wait list policy. Victorian Department of Human Services, Melbourne. Viewed 17 August 2011, http://docs.health.vic.gov.au/docs/doc/Public-dental-non-urgent-care-wait-list-policy-July-2007

Data element attributes

Collection and usage attributes

Guide for use: Jurisdictions often maintain separate waiting lists for different categories of dental treatment. For example, a person waiting for dentures will be placed on a denture waiting list, while a person waiting for a check-up may be placed on a waiting list for general dental care. The lists are likely to have different waiting times so it is necessary to differentiate between lists.

The "Assessment" code should only be used if the person is placed on a specific waiting list for assessment which is distinct from the waiting lists for general dental care or denture care. If the jurisdiction does not have a separate "Assessment" waiting list, then waiting list episodes should be recorded using the "General dental care" or "Denture care" codes, even if an assessment to determine future treatment is included in the course of care.

The calculation of total waiting time will differ between jurisdictions that use an assessment waiting list and those that do not.

In cases where a person is on a waiting list for both general dental care and denture care - for example, a person with natural teeth requiring partial dentures is placed on a waiting list for denture care following completion of general care - this should be counted as two separate waiting list episodes.

In cases where a person is on a waiting list for combined general and denture care - that is, a person with natural teeth requiring partial denture treatment is given partial denture treatment within a course of general care without a person being placed on a denture waiting list - this should be counted as a single general care waiting list episode.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: Public dental waiting times DSS 2012-13 Health, Superseded 09/11/2012

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Public dental waiting times NMDS 2013- Health, Standard 09/11/2012

Implementation start date: 01/07/2013

◊ Recurrent expenditure (salaries and wages)—mental health carer workers

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (mental health carer workers) (financial year), total Australian currency N[N(8)]
METeOR identifier:	451432
Registration status:	Health, Standard 07/02/2013
Definition:	Salary and wage payments to **mental health carer workers** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Mental health carer workers are persons employed (or engaged via contract) on a part-time or full-time basis, i.e. the person received a salary or contract fee on a regular basis. It does not refer to arrangements where the carer worker only received reimbursements of expenses or occasional sitting fees for attendance at meetings. Mental health carer workers employed at the jurisdictional or regional level are considered in-scope. Salary costs should be apportioned between all establishments, as deemed appropriate by the jurisdiction (full-time-equivalent staff figures should be apportioned on the same basis).
Collection methods:	Note: This code is only to be reported for the Mental Health Establishments NMDS. For Public hospital establishments NMDS data are to be reported in a category according to specific state and territory arrangements.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

Supersedes Establishment—recurrent expenditure (salaries and wages) (carer consultants) (financial year), total Australian currency N[N(8)] Health, Superseded 07/02/2013

Implementation in Data Set Specifications:

Mental health establishments NMDS 2013-14 Health, Superseded 07/03/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Mental health establishments NMDS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Mental health establishments NMDS 2015-16 Health, Candidate 12/08/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

◊ Recurrent expenditure (salaries and wages)—mental health consumer workers

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—recurrent expenditure (salaries and wages) (mental health consumer workers) (financial year), total Australian currency N[N(8)]
METeOR identifier:	451428
Registration status:	Health, Standard 07/02/2013
Definition:	Salary and wage payments to **mental health consumer workers** of an establishment, for a financial year.
Data Element Concept:	Establishment—recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Currency
Format:	N[N(8)]
Maximum character length:	9
Unit of measure:	Australian currency (AU$)

Data element attributes

Collection and usage attributes

Guide for use:	Mental health consumer workers are persons employed (or engaged via contract) on a part-time or full-time basis, i.e. the person received a salary or contract fee on a regular basis. It does not refer to arrangements where the consumer worker only received reimbursements of expenses or occasional sitting fees for attendance at meetings. Mental health consumer workers employed at the jurisdictional or regional level are considered in-scope. Salary costs should be apportioned between all establishments, as deemed appropriate by the jurisdiction (full-time-equivalent staff figures should be apportioned on the same basis).
Collection methods:	Note: This code is only to be reported for the Mental Health Establishments NMDS. For Public hospital establishments NMDS data are to be reported in a category according to specific state and territory arrangements.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

Supersedes Establishment—recurrent expenditure (salaries and wages) (consumer consultants) (financial year), total Australian currency N[N(8)] Health, Superseded 07/02/2013

Implementation in Data Set Specifications:

Mental health establishments NMDS 2013-14 Health, Superseded 07/03/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Mental health establishments NMDS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Mental health establishments NMDS 2015-16 Health, Candidate 12/08/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

◊ Specialised mental health service setting

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service organisation—service delivery setting, code N
METeOR identifier:	493347
Registration status:	Health, Standard 07/02/2013
Definition:	The service delivery setting for the components of a specialised mental health service organisation, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—service delivery setting

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Admitted patient care setting
2	Residential care setting
3	Ambulatory care setting
4	Organisational overhead setting

Collection and usage attributes

Guide for use:

CODE 1 Admitted patient care setting

The component of specialised mental health service organisations that provides admitted patient care within **Admitted patient mental health care services**.

CODE 2 Residential care setting

The component of specialised mental health organisations that provides residential care within **Residential mental health care services**.

CODE 3 Ambulatory care setting

The component of specialised mental health service organisations that provides ambulatory care (service contacts) by **Ambulatory mental health care services**.

CODE 4 Organisational overhead setting

The components of specialised mental health service organisations not directly involved in the delivery of patient care services in the admitted patient, residential or ambulatory mental health care service settings, or in the operations of those settings.

Data element attributes

Collection and usage attributes

Guide for use:

The intention of the 'Organisation overhead setting' category is to separately identify staff not directly involved in the delivery of patient care services in the Admitted patient, Residential or Ambulatory mental health care service settings, or in the operations of those settings. Note that this does not imply that these roles do not have an impact on service delivery.

Staff employed to deliver patient care services should be reported in the Admitted patient (code 1), Residential (code 2) or Ambulatory (code 3) mental health care settings, as appropriate. Staff employed in the administration of a particular service would also be reported against the appropriate service setting. For example, administrative and domestic staff specifically attached to an admitted patient unit would be reported at the Admitted patient care service setting.

Organisational staff not directly involved in the delivery of patient care services should be reported in the Organisational overhead setting (code 4). For example, a chief operating officer not directly providing patient care, nor involved in the operation of services in a specific service setting, would be reported in the Organisational overhead setting.

Some staff may require apportioning across a number of service settings. For example, a clinical director, with oversight of all services provided by the organisation, would be apportioned across the service settings based on the level of involvement with each of these services.

This data element permits staffing data related to service settings to be identified and reported separately.

Regional and jurisdictional level staff are excluded from full-time equivalent staff data for the MHE NMDS.

Relational attributes

Related metadata references:

Supersedes Specialised mental health service—service setting, code N Health, Superseded 07/02/2013

See also Specialised mental health service—target population group, code N Health, Standard 07/02/2013

Implementation in Data Set Specifications:

Mental health establishments NMDS 2013-14 Health, Superseded 07/03/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Mental health establishments NMDS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Mental health establishments NMDS 2015-16 Health, Candidate 12/08/2014

Implementation start date: 01/07/2015
Implementation end date: 30/06/2016

◊ Specialised mental health service target population

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Specialised mental health service—target population group, code N
METeOR identifier:	493010
Registration status:	Health, Standard 07/02/2013
Definition:	The population group primarily targeted by a specialised mental health service, as represented by a code.
Data Element Concept:	Specialised mental health service—specialised mental health service target population group

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Child and adolescent
2	Older person
3	Forensic
4	General
5	Youth

Supplementary values:

Value	Meaning
7	Not applicable
9	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:

This data element is used to disaggregate data on beds, activity, expenditure and staffing for patients in mental health service units (see the *Specialised mental health service – service setting, code N* data element).

CODE 1 Child and adolescent

These services principally target children and young people under the age of 18 years. The classification of a service into this category requires recognition by the regional or central funding authority of the special focus of the service. These services may

include a forensic component.

CODE 2 Older person

These services principally target people in the age group of 65 years and over. The classification of a service into this category requires recognition by the regional or central funding authority of the special focus of the service. These services may include a forensic component.

CODE 3 Forensic

Health services that provide services primarily for people whose health condition has led them to commit, or be suspected of, a criminal offence or make it likely that they will reoffend without adequate treatment or containment. This includes prison-based services, but excludes services that are primarily for children and adolescents and for older people even where they include a forensic component.

CODE 4 General

These services principally target the general adult population (aged 18–64 years) but may also provide services to children, adolescents or older people. These services are those services that cannot be described as specialist child and adolescent services, youth services or services for older people. It excludes forensic services.

CODE 5 Youth

These services principally target children and young people generally aged 16-24 years. The classification of a service into this category requires recognition by the regional or central funding authority of the special focus of the service. These services may include a forensic component.

The order of priority for coding is:

- where the forensic services are for children/adolescents, youth or older persons these services should be coded to the category for that age group; and
- where the forensic services are for adults these services should be coded to forensic.

CODE 7 Not applicable

The code is only for use to identify those components of specialised mental health service organisations not directly involved in the delivery of patient care services in the admitted patient, residential or ambulatory mental health care services, nor in the operations of those services.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also Specialised mental health service organisation—service delivery setting, code N Health, Standard 07/02/2013

See also Specialised mental health service—admitted patient service unit identifier, XXXXXX Health, Standard 07/12/2011

See also Specialised mental health service—admitted patient

service unit name, text XXX[X(97)] Health, Standard 07/12/2011

See also Specialised mental health service—ambulatory service unit identifier, XXXXXX Health, Standard 07/12/2011

See also Specialised mental health service—ambulatory service unit name, text XXX[X(97)] Health, Standard 07/12/2011

See also Specialised mental health service—residential service unit identifier, XXXXXX Health, Standard 07/12/2011

See also Specialised mental health service—residential service unit name, text XXX[X(97)] Health, Standard 07/12/2011

Supersedes Specialised mental health service—target population group, code N Health, Superseded 07/02/2013

Implementation in Data Set Specifications:

Community mental health care NMDS 2013-14 Health, Superseded 07/03/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Community mental health care NMDS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Community mental health care NMDS 2015-16 Health, Candidate 12/08/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

Mental health establishments NMDS 2013-14 Health, Superseded 07/03/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Mental health establishments NMDS 2014-15 Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Mental health establishments NMDS 2015-16 Health, Candidate 12/08/2014

Implementation start date: 01/07/2015

Implementation end date: 30/06/2016

Mental health seclusion and restraint DSS 2015- Health, Candidate 21/08/2014

Implementation start date: 01/07/2015

▲ Specimen collection date

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—specimen collection date, DDMMYYYY
METeOR identifier:	428420
Registration status:	Health, Standard 15/11/2012
Definition:	The date on which the specimen was collected from the person, expressed as DDMMYYYY.
Data Element Concept:	Person—specimen collection date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	Record the date when the specimen was collected.

Source and reference attributes

Submitting organisation:	Australian Commission on Safety and Quality in Health Care (ACSQHC)
Origin:	ACSQHC Healthcare Associated Infection Technical Working Group

Relational attributes

Implementation in Data Set Specifications:	Surveillance of healthcare associated infection: Clostridium difficile infection DSS Health, Standardisation pending 23/07/2012 Surveillance of healthcare associated infection: *Staphylococcus aureus* bacteraemia DSS Health, Standard 15/11/2012

▲ Specimen collection time

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Person—specimen collection time, hhmm
METeOR identifier:	438491
Registration status:	Health, Standard 15/11/2012
Definition:	The time at which the specimen was collected from the person, presented in 24 hour time.
Data Element Concept:	Person—specimen collection time

Value domain attributes

Representational attributes

Representation class:	Time
Data type:	Date/Time
Format:	hhmm
Maximum character length:	4

Source and reference attributes

Reference documents:	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times

Data element attributes

Collection and usage attributes

Guide for use:	Record the time when the specimen was collected.

Source and reference attributes

Submitting organisation:	Australian Commission on Safety and Quality in Health Care
Origin:	Australian Commission on Safety and Quality in Health Care Healthcare Associated Infection Technical Working Group

Relational attributes

Implementation in Data Set Specifications:	Surveillance of healthcare associated infection: Clostridium difficile infection DSS Health, Standardisation pending 23/07/2012 Surveillance of healthcare associated infection: *Staphylococcus aureus* bacteraemia DSS Health, Standard 15/11/2012

▲ Specimen identifier

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Laboratory—specimen identifier, text X[X(39)]
METeOR identifier:	428518
Registration status:	Health, Standard 15/11/2012
Definition:	Specimen identifier unique within a laboratory, as represented by text.
Data Element Concept:	Laboratory—specimen identifier

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	X[X(39)]
Maximum character length:	40

Data element attributes

Collection and usage attributes

Guide for use:	The assignment of an identifier to a specimen allows the tracking of the specimen through receipt, processing, analysis, reporting and storage within the laboratory.
Collection methods:	

Source and reference attributes

Submitting organisation:	Australian Commission on Safety and Quality in Health Care (ACSQHC)
Origin:	ACSQHC Healthcare Associated Infection Technical Working Group

Relational attributes

Implementation in Data Set Specifications:	Surveillance of healthcare associated infection: Clostridium difficile infection DSS Health, Standardisation pending 23/07/2012 Surveillance of healthcare associated infection: *Staphylococcus aureus* bacteraemia DSS Health, Standard 15/11/2012

▲ *Staphylococcus aureus* bacteraemia methicillin susceptibility indicator

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient episode of *Staphylococcus aureus* bacteraemia—*Staphylococcus aureus* methicillin susceptibility indicator, yes/no code N
METeOR identifier:	458522
Registration status:	Health, Standard 15/11/2012
Definition:	An indicator of whether the *Staphylococcus aureus* bacteraemia (SAB) isolate is susceptible to oxacillin or methicillin (cefoxitin), as represented by a code.
Data Element Concept:	Patient episode of *Staphylococcus aureus* bacteraemia—*Staphylococcus aureus* methicillin susceptibility indicator

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Boolean
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Yes
2	No

Data element attributes

Collection and usage attributes

Guide for use:

This data element is used to record whether the *Staphylococcus aureus* organism is Methicillin-susceptible (MSSA) or Methicillin-resistant (MRSA).

CODE 1 Yes

Record if the *Staphylococcus aureus* isolate is susceptible to oxacillin or methicillin (cefoxitin) (MSSA).

CODE 2 No

Record if the *Staphylococcus aureus* isolate is resistant to oxacillin or methicillin (cefoxitin) (MRSA).

Intermediate level resistance is reported as 2 (resistant).

Source and reference attributes

Submitting organisation:	Australian Commission on Safety and Quality in Health Care (ACSQHC)
Origin:	ACSQHC Healthcare Associated Infection Technical Working Group

Relational attributes

Implementation in Data Set Specifications:	Surveillance of healthcare associated infection: *Staphylococcus aureus* bacteraemia DSS Health, Standard 15/11/2012

▲ *Staphylococcus aureus* bacteraemia status

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Patient episode of *Staphylococcus aureus* bacteraemia—*Staphylococcus aureus* bacteraemia status, code N
METeOR identifier:	458219
Registration status:	Health, Standard 15/11/2012
Definition:	Identifies whether the patient episode of *Staphylococcus aureus* bacteraemia (SAB) is healthcare associated or community-acquired, as represented by a code.
Data Element Concept:	Patient episode of *Staphylococcus aureus* bacteraemia—*Staphylococcus aureus* bacteraemia status

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values: / *Supplementary values:*

Value	Meaning
1	Healthcare associated
2	Community-acquired
8	Unknown
9	Not stated/inadequately described

Source and reference attributes

Submitting organisation:	Australian Commission on Safety and Quality in Health Care (ACSQHC)
Origin:	ACSQHC Healthcare Associated Infection Technical Working Group

Data element attributes

Collection and usage attributes

Guide for use:

A *Staphylococcus aureus* bacteraemia (SAB) will be considered to be a healthcare associated event if:

EITHER

The patient's first SAB positive blood culture was collected more than 48 hours after hospital admission or less than 48 hours after discharge.

OR

The patient's first positive SAB blood culture was collected less than or equal to 48 hours after hospital admission and one or more of the following key clinical criteria was met for the patient-episode of SAB:

1. SAB is a complication of the presence of an indwelling medical device (e.g. intravascular line, haemodialysis vascular access, CSF shunt, urinary catheter)
2. SAB occurs within 30 days of a surgical procedure where the SAB is related to the surgical site
3. SAB was diagnosed within 48 hours of a related invasive instrumentation or incision
4. SAB is associated with neutropenia (Neutrophils: less than 1 x 10^9/L) contributed to by cytotoxic therapy

If none of these criteria are met, then the episode of SAB is considered to be community-acquired for the purposes of surveillance.

Comments: To identify whether SABs are healthcare associated or community-acquired, SABs should undergo a standard case review by a healthcare worker trained in Infectious Diseases/Infection Control.

Source and reference attributes

Submitting organisation: Australian Commission on Safety and Quality in Health Care (ACSQHC)

Origin: ACSQHC Healthcare Associated Infection Technical Working Group

Relational attributes

Implementation in Data Set Specifications: Surveillance of healthcare associated infection: *Staphylococcus aureus* bacteraemia DSS Health, Standard 15/11/2012

◊ Type of anaesthesia administered during a birth event

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—type of anaesthesia administered, code N[N]
METeOR identifier:	422383
Registration status:	Health, Standard 07/02/2013
Definition:	The type of **anaesthesia** administered to a woman during a birth event, as represented by a code.
Data Element Concept:	Birth event—type of anaesthesia administered

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
2	Local anaesthetic to perineum
3	Pudendal block
4	Epidural or caudal block
5	Spinal block
6	General anaesthesia
7	Combined spinal-epidural block
88	Other anaesthesia

Supplementary values:

Value	Meaning
99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 7 Combined spinal-epidural block

The spinal-epidural block combines the benefits of rapid action of a spinal block and the flexibility of an epidural block. An epidural catheter inserted during the technique enables the provision of long-lasting analgesia with the ability to titrate the dose for the desired effect.

CODE 88 Other anaesthesia

May include parenteral opioids, nitrous oxide.

Comments: Note: Code 1, which had a meaning in previous versions of the data standard, is no longer used. As is good practice, the code will not be reused.

Data element attributes

Collection and usage attributes

Guide for use: This data element should be used in conjunction with the data element: *Birth event – anaesthesia administered indicator, yes/no code N* to obtain information on if anaesthesia was administered to a woman during the birth event.

Collection methods: More than one technique can be recorded.

Code 7 cannot be recorded if Code 4 and Code 5 have already been recorded.

This item should be recorded for operative or instrumental delivery of the baby only. It does not include the removal of the placenta.

Comments: Anaesthetic use may affect the health status of the baby and is an indicator of obstetric intervention.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: See also Birth event—anaesthesia administered indicator, yes/no code N Health, Standard 07/02/2013

Supersedes Birth event—anaesthesia administered, code N Health, Superseded 07/02/2013

Implementation in Data Set Specifications: Perinatal NMDS 2013-14 Health, Superseded 07/03/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Conditional obligation:
This data element is to only be reported in cases where anaesthesia was administered to the mother during the birth event.

Perinatal NMDS 2014- Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:
This data element is to only be reported in cases where anaesthesia was administered to the mother during the birth event.

Implementation in Indicators: **Used as numerator**
National Core Maternity Indicators: PI 09-General anaesthetic for women giving birth by caesarean section (2013) Health, Candidate 03/07/2014

◊ Type of analgesia administered during a birth event

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Birth event—type of analgesia administered, code N[N]
METeOR identifier:	471867
Registration status:	Health, Standard 07/02/2013
Definition:	The type of **analgesia** administered to the woman during a birth event, as represented by a code.
Data Element Concept:	Birth event—type of analgesia administered

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

Permissible values:

Value	Meaning
2	Nitrous oxide
4	Epidural or caudal block
5	Spinal block
6	Systemic opioids
7	Combined spinal-epidural block
88	Other analgesia

Supplementary values:

99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 6 Systemic opioids

Includes intramuscular and intravenous opioids.

CODE 7 Combined spinal-epidural block

The spinal-epidural block combines the benefits of rapid action of a spinal block and the flexibility of an epidural block. An epidural catheter inserted during the technique enables the provision of long-lasting analgesia with the ability to titrate the dose for the desired effect.

CODE 88 Other analgesia

Includes all non-narcotic oral analgesia. Includes non-pharmacological methods such as hypnosis, acupuncture, massage, relaxation techniques, temperature regulation, aroma therapy and other.

Comments:

Note: Code 1 and Code 3, which each had a meaning in previous versions of the data standard, are no longer used. As is good practice, the codes will not be reused.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Data element attributes

Collection and usage attributes

Guide for use: This data element should be used in conjunction with the data element: *Birth event – analgesia administered indicator, yes/no code N* to obtain information on if analgesia was administered to a woman during the birth event.

Collection methods: More than one agent or technique can be recorded.

Code 7 cannot be recorded if Code 4 and Code 5 have already been recorded.

This item is to be recorded for first and second stage labour, but not for third stage labour, e.g. removal of placenta.

Comments: Analgesia use may influence the duration of labour, may affect the health status of the baby at birth and is an indicator of obstetric intervention. Analgesia may also influence a woman's satisfaction with her birth experience and is an indicator of women's access to anaesthesia services, i.e. epidural analgesia is not available for women in birth events where there are no anaesthetic services.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: See also Birth event—analgesia administered indicator, yes/no code N Health, Standard 07/02/2013

Supersedes Birth event—analgesia administered, code N Health, Superseded 07/02/2013

Implementation in Data Set Specifications: Perinatal NMDS 2013-14 Health, Superseded 07/03/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Conditional obligation:
This data element is to only be reported in cases where analgesia was administered to the mother during the birth event.

Perinatal NMDS 2014- Health, Standard 07/03/2014

Implementation start date: 01/07/2014

Implementation end date: 30/06/2015

Conditional obligation:
This data element is to only be reported in cases where analgesia was administered to the mother during the birth event.

◊ Urgency related group

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Emergency department stay—urgency related group, URG (v1.3) code [X]N[N]
Synonymous names:	URG
METeOR identifier:	498030
Registration status:	Health, Standard 07/02/2013 Independent Hospital Pricing Authority, Standard 31/10/2012
Definition:	A patient classification scheme which provides a means of relating the number and types of patients treated in an **emergency department**, as represented by a code.
Data Element Concept:	Emergency department care—urgency related group

Value domain attributes

Representational attributes

Classification scheme:	Urgency Related Group classification (version 1.3)
Representation class:	Code
Data type:	String
Format:	[X]N[N]
Maximum character length:	3

Source and reference attributes

Submitting organisation:	Independent Hospital Pricing Authority

Data element attributes

Collection and usage attributes

Comments:	The urgency related group (URG) is derived from the urgency disposition group (UDG) which classifies patients into 12 groups based on disposition (admitted or discharged) and urgency (triage category 1-5), including a category for patients who did not wait for treatment as well as a category for patients who died. The URG classification system segments the UDG classification system further by using 26 major diagnostic blocks.

Source and reference attributes

Submitting organisation:	Independent Hospital Pricing Authority
Reference documents:	Jelinek G (1994). Case-mix Classification of Patients Attending Hospital Emergency Departments in Perth Western Australia. Doctor of Medicine Thesis. Perth Australia. University of Western Australia.

Relational attributes

Related metadata references:

See also Emergency department stay—urgency related group major diagnostic block, code N[AA] Health, Superseded 11/04/2014, Independent Hospital Pricing Authority, Standard 31/10/2012

Supersedes Emergency department stay—urgency related group, URG (v1.2) code [X]N[N] Independent Hospital Pricing Authority, Superseded 31/10/2012

Implementation in Data Set Specifications:

Activity based funding: Emergency department care DSS 2013-2014 Independent Hospital Pricing Authority, Superseded 01/03/2013

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Non-admitted patient emergency department care NMDS 2013-14 Health, Superseded 11/04/2014

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

◊ Waiting list category

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Elective care waiting list episode—elective care type, code N
METeOR identifier:	514023
Registration status:	Health, Standard 02/05/2013
Definition:	The type of elective hospital care that a patient requires, as represented by a code.
Data Element Concept:	Elective care waiting list episode—elective care type

Value domain attributes

Representational attributes

Classification scheme:	Australian Classification of Health Interventions (ACHI) 8th edition
Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Elective surgery
2	Other

Collection and usage attributes

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.

CODE 1 Elective surgery

All elective surgery, that is excluding procedures listed in the exclusion list for Code 2 below, should be included in this code.

CODE 2 Other

Patients awaiting the following procedures should be classified as Code 2 - Other:

- biopsy of:
  - kidney (needle only)
  - lung (needle only)
  - liver and gall bladder (needle only)
- bronchoscopy (including fibre-optic bronchoscopy)
- cosmetic surgery not attracting a Medicare rebate
- dental procedures not attracting a Medicare rebate

- endoscopy of:
  - biliary tract and pancreas
  - oesophagus
  - large intestine, rectum and anus
- endovascular interventional procedures
- in vitro fertilisation
- miscellaneous cardiac procedures
- miscellaneous lower urinary tract procedures
- obstetrics
- organ or tissue transplant
- panendoscopy (except when involving the bladder)
- peritoneal and renal dialysis
- procedures associated with obstetrics (e.g. elective caesarean section, cervical suture)
- other diagnostic and non-surgical procedures.

These procedure terms are also defined by the Australian Classification of Health Interventions (ACHI) codes which are listed in the Comments field below. This coded list is the recommended, but optional, method for determining whether a patient is classified as requiring elective surgery or other care.

Comments:

The table of Australian Classification of Health Interventions (ACHI) (8th edition) 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 to more readily facilitate the identification of the exclusions when the list of codes is not used.

ACHI codes for the excluded procedures:

Biopsy (needle) of:
• kidney: 36561-00 [1047]
• lung: 38812-00 [550]
• liver and gall bladder: 30409-00 [953] 30412-00 [953] 90319-01 [951] 30094-04 [964]

Bronchoscopy (including fibre-optic 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]

Dental procedures not attracting a Medicare rebate:
Blocks [450] to [490]
97022-00 [451] 97025-00 [451] 97113-00 [453] 97121-01 [454] 97123-01 [454] 97165-01 [455] 97221-00 [456] 97222-00 [456] 97231-00 [456] 97232-00 [456] 97233-00 [456] 97234-00 [456] 97384-00 [461] 97386-01 [461] 97415-00 [462] 97417-00 [462] 97431-00 [463] 97433-00 [463] 97434-00 [463] 97437-00 [463] 97445-00 [464]

97455-00 [464] 97511-01 [465] 97512-01 [465]
97513-01 [465] 97514-02 [465] 97515-02 [465]
97541-01 [465] 97542-01 [465] 97543-01 [465]
97544-00 [465] 97545-00 [465] 97521-01 [466]
97522-01 [466] 97523-01 [466] 97524-00 [466]
97525-00 [466] 97531-00 [466] 97532-00 [466]
97533-00 [466] 97534-00 [466] 97535-00 [466]
97551-01 [466] 97552-01 [466] 97553-01 [466]
97554-01 [466] 97555-01 [466] 97572-01 [469]
97574-01 [469] 97575-00 [469] 97578-00 [469]
97582-01 [469] 97583-01 [469] 97631-00 [470]
97632-00 [471] 97649-00 [471] 97671-00 [473]
97672-00 [473] 97673-00 [473] 97732-00 [474]
97733-00 [474] 97739-00 [474] 97741-00 [475]
97762-00 [476] 97765-00 [476] 97768-00 [476]
97825-00 [479]

Endoscopy of biliary tract and pancreas:
30484-00 [957] 30484-01 [957] 30484-02 [974]
30494-00 [971] 30452-00 [971] 30491-00 [958]
30491-02 [975] 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] 41825-00 [852]
30478-12 [856] 41831-00 [862] 30478-12 [856]
30490-00 [853] 30479-00 [856]

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]

Endovascular interventional procedures:
38300-01 [670] 38303-00 [670] 38300-00 [670]
38303-01 [670] 38306-00 [671] 38306-01 [671]
38306-03 [671] 38306-04 [671] 38306-02 [671]
38306-05 [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]

In vitro fertilisation:
13209-00 [1297] 13206-00 [1297] 13200-00 [1297]
13203-00 [1297] 13212-00 [1297] 13212-01 [1297]
13215-00 [1297] 13215-01 [1297] 13215-02 [1297]
13215-03 [1297]

Miscellaneous cardiac procedures:
38603-00 [642] 38600-00 [642] 38256-00 [647]
38256-01 [647] 38350-00 [648] 90202-00 [649]
38470-00 [649] 38473-00 [649] 38353-00 [650]
38358-00 [654] 38358-01 [654] 38368-02 [654]

90203-00 [654] 38350-02 [654] 90219-00 [663]
38353-02 [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]
38368-00 [648] 90202-01 [649] 38358-02 [654]
38654-02 [654] 38456-26 [654] 38456-27 [654]
90203-04 [654] 38456-25 [654] 38350-02 [654]
38287-01 [601] 38287-02 [601] 38213-00 [665]

Miscellaneous lower urinary tract procedures:
36800-00 [1090] 36800-01 [1090] 37011-00 [1093]
37008-01 [1093] 37008-00 [1093] 37315-00 [1112]
37318-01 [1116] 36815-01 [1116] 37854-00 [1116]
35527-00 [1116] 37318-04 [1117] 36800-03 [1090]
37318-02 [1116] 37318-03 [1116]

Obstetric:
Blocks [1330] to [1345] and [1347]
90463-01 [1330] 90488-00 [1330]

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]

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]

Peritoneal and renal dialysis:
13100-06 [1061] 13100-07 [1061] 13100-08 [1061]
13100-00 [1060]

Procedures associated with obstetrics:
16511-00 [1274]

Other diagnostic and non-surgical procedures:
90347-01 [983] 30406-00 [983] 90347-02 [983]
30408-00 [983]
Blocks [1820] to [1939], [1940] to [2016]
11003-00 [1825] 11018-00 [1826] 11018-01 [1826]
11614-00 [1851] 11602-00 [1852] 11604-00 [1852]
11605-00 [1852] 11610-00 [1852] 11611-00 [1852]
11612-00 [1852] 11709-00 [1853] 11917-00 [1860]
11919-00 [1860] 96209-00 [1920] 96209-01 [1920]
96209-02 [1920] 96209-03 [1920] 96209-04 [1920]
13706-05 [1893] 96209-06 [1920] 96209-07 [1920]
96209-08 [1920] 96209-09 [1920] 55084-00 [1943]
55600-00 [1943] 60000-01 [1992] 60048-00 [1996]
60060-00 [1997] 60060-01 [1997] 61442-00 [2012]
96196-00 [1920] 96196-01 [1920] 96196-02 [1920]

96196-03 [1920] 96196-04 [1920] 13706-05 [1893]
96196-06 [1920] 96196-07 [1920] 96196-08 [1920]
96196-09 [1920] 96197-00 [1920] 96197-01 [1920]
96197-02 [1920] 96197-03 [1920] 96197-04 [1920]
96197-06 [1920] 96197-07 [1920] 96197-08 [1920]
96197-09 [1920] 96198-00 [1920] 96198-01 [1920]
96198-02 [1920] 96198-03 [1920] 96198-04 [1920]
96198-06 [1920] 96198-07 [1920] 96198-08 [1920]
96198-09 [1920] 96199-00 [1920] 96199-01 [1920]
96199-02 [1920] 96199-03 [1920] 96199-04 [1920]
96199-06 [1920] 96199-07 [1920] 96199-08 [1920]
96199-09 [1920] 96200-00 [1920] 96200-01 [1920]
96200-02 [1920] 96200-03 [1920] 96200-04 [1920]
96200-06 [1920] 96200-07 [1920] 96200-08 [1920]
96200-09 [1920] 96201-00 [1920] 96201-01 [1920]
96201-02 [1920] 96201-03 [1920] 96201-04 [1920]
96201-06 [1920] 96201-07 [1920] 96201-08 [1920]
96201-09 [1920] 96202-00 [1920] 96202-01 [1920]
96202-02 [1920] 96202-03 [1920] 96202-04 [1920]
96202-06 [1920] 96202-07 [1920] 96202-08 [1920]
96202-09 [1920] 96203-00 [1920] 96203-01 [1920]
96203-02 [1920] 96203-03 [1920] 96203-04 [1920]
96203-06 [1920] 96203-07 [1920] 96203-08 [1920]
96203-09 [1920] 96199-00 [1920] 96199-01 [1920]
96199-02 [1920] 96199-03 [1920] 96199-04 [1920]
13706-05 [1893] 96199-06 [1920] 96199-07 [1920]
96199-08 [1920] 96199-09 [1920] 96205-00 [1920]
96205-01 [1920] 96205-02 [1920] 96205-03 [1920]
96205-04 [1920] 96205-06 [1920] 96205-07 [1920]
96205-08 [1920] 96205-09 [1920] 96206-00 [1920]
96206-01 [1920] 96206-02 [1920] 96206-03 [1920]
96206-04 [1920] 96206-06 [1920] 96206-07 [1920]
96206-08 [1920] 96206-09 [1920]

Source and reference attributes

Reference documents: National Centre for Classification in Health (NCCH) 2010. The Australian Classification of Health Interventions (ACHI) – Eight Edition - Tabular list of interventions and Alphabetic index of interventions. Sydney: NCCH, Faculty of Health Sciences, The University of Sydney.

Data element attributes

Collection and usage attributes

Collection methods: This data element is necessary for determining whether patients are in scope for both the Elective surgery waiting times (census data) NMDS 2013- and the Elective surgery waiting times (removals data) NMDS 2013- but is not explicitly included in either NMDS.

Source and reference attributes

Submitting organisation: Hospital Access Program Waiting Lists Working Group

Waiting Times Working Group

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes Elective care waiting list episode—elective care type, code N Health, Superseded 02/05/2013

See also Elective surgery waiting times (census data) NMDS 2013- Health, Standard 02/05/2013

See also Elective surgery waiting times (removals data) NMDS 2013- Health, Standard 02/05/2013

▲ Ward/clinical area

Identifying and definitional attributes

Metadata item type:	Data Element
Technical name:	Establishment—ward/clinical area name, text X[X(39)]
METeOR identifier:	389201
Registration status:	Health, Standard 15/11/2012
Definition:	The organisational unit or organisational arrangement dedicated to the treatment and care of admitted patients in a healthcare setting, as represented by text.
Data Element Concept:	Establishment—ward/clinical area name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	X[X(39)]
Maximum character length:	40

Data element attributes

Collection and usage attributes

Guide for use:	This data element refers to the ward or clinical area within the healthcare facility where the patient was located. This information will be facility specific, so local conventions for naming wards should be used, for example Maternity Ward, or Emergency Department.

Source and reference attributes

Submitting organisation:	Australian Commission on Safety and Quality in Health Care (ACSQHC)
Origin:	Australian Commission on Safety and Quality in Health Care Healthcare Associated Infection Technical Working Group

Relational attributes

Implementation in Data Set Specifications:	Surveillance of healthcare associated infection: Clostridium difficile infection DSS Health, Standardisation pending 23/07/2012 Surveillance of healthcare associated infection: *Staphylococcus aureus* bacteraemia DSS Health, Standard 15/11/2012

National minimum data sets

Admitted patient mental health care NMDS 2013-14

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	504646
Registration status:	Health, Standard 02/05/2013
DSS type:	National Minimum Data Set (NMDS)
Scope:	The scope of the Admitted patient mental health care national minimum data set (NMDS) 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.

Collection and usage attributes

Statistical unit:	Episodes of care for admitted patients
Collection methods:	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.
Implementation start date:	01/07/2013
Implementation end date:	30/06/2014
Comments:	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. *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

- Admitted patient palliative care NMDS

Glossary items

Glossary terms that are relevant to this National minimum data set are included here.

Resident

Residential mental health care service

Same-day patients

Separation

Source and reference attributes

Submitting organisation: National Health Information Group

Relational attributes

Related metadata references: Supersedes Admitted patient mental health care NMDS 2012-13 Health, Superseded 02/05/2013

Has been superseded by Admitted patient mental health care NMDS 2014-15 Health, Standardisation pending 18/07/2014

Implementation in Data Set Specifications: Activity based funding: Admitted acute hospital care DSS 2013-2014 Independent Hospital Pricing Authority, Superseded 01/03/2013

Implementation start date: 01/07/2013

Implementation end date: 30/06/2014

Conditional obligation:
Only required to be reported for episodes of care for admitted patients which occur partly or fully in designated psychiatric units of public acute hospitals or in public psychiatric hospitals

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Additional diagnosis	Mandatory	1
-	Admission date	Mandatory	1
-	Area of usual residence (SA2)	Mandatory	1
-	Care type	Mandatory	1
-	Country of birth	Mandatory	1
-	Date of birth	Mandatory	1
-	Employment status (admitted patient)	Mandatory	1
-	Employment status—public psychiatric hospital admissions	Mandatory	1
-	Establishment identifier	Mandatory	1
-	Indigenous status	Mandatory	1
-	Marital status	Conditional	1
-	Mental health legal status	Mandatory	1
-	Mode of separation	Mandatory	1
-	Person identifier	Mandatory	1
-	Previous specialised treatment	Mandatory	1

-	Principal diagnosis—episode of care	Mandatory	1
-	Referral destination to further care (psychiatric patients)	Mandatory	1
-	Separation date	Mandatory	1
-	Sex	Mandatory	1
-	Source of referral to public psychiatric hospital	Mandatory	1
-	Total leave days	Mandatory	1
-	Total psychiatric care days	Mandatory	1
-	Type of accommodation	Mandatory	1
-	Type of usual accommodation	Mandatory	1

Admitted patient palliative care NMDS 2013-14

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	504641
Registration status:	Health, Standard 02/05/2013
DSS type:	National Minimum Data Set (NMDS)
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 *Hospital service – care type, code N[N].*

Collection and usage attributes

Statistical unit:	Episodes of care for admitted patients.
Collection methods:	*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 collected and collated nationally* Financial years ending 30 June each year.
Implementation start date:	01/07/2013
Implementation end date:	30/06/2014
Comments:	*Scope links with other NMDSs* Episodes of care for admitted patients receiving palliative care in all public and private acute hospitals and free standing day hospital facilities: • Admitted patient care NMDS. • Admitted patient mental health care NMDS. *Glossary items* Glossary terms that are relevant to this National minimum data set are included here. **Admission** **Hospital boarder** **Hospital-in-the-home care** **Newborn qualification status** **Organ procurement - posthumous** **Separation**

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Relational attributes

Related metadata references:	Supersedes Admitted patient palliative care NMDS 2012-13

Health, Superseded 02/05/2013
Has been superseded by Admitted patient palliative care NMDS 2014-15 Health, Standardisation pending 18/07/2014

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Additional diagnosis	Conditional	1
-	Admission date	Mandatory	1
-	Area of usual residence (SA2)	Mandatory	1
-	Care type	Mandatory	1
-	Country of birth	Mandatory	1
-	Date of birth	Mandatory	1
-	Establishment identifier	Mandatory	1
-	Funding source for hospital patient	Mandatory	1
-	Indigenous status	Mandatory	1
-	Mode of admission	Mandatory	1
-	Mode of separation	Mandatory	1
-	Number of days of hospital-in-the-home care	Mandatory	1
-	Person identifier	Mandatory	1
-	Previous specialised treatment	Mandatory	1
-	Principal diagnosis—episode of care	Mandatory	1
-	Separation date	Mandatory	1
-	Sex	Mandatory	1

Alcohol and other drug treatment services NMDS 2013-15

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 498901

Registration status: Health, Standard 07/02/2013

DSS type: National Minimum Data Set (NMDS)

Scope: The Alcohol and other drug treatment services national minimum data set (NMDS) 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 'half-way 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; and
- 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.

Collection and usage attributes

Statistical unit: Completed treatment episodes for clients who participate in a treatment type as specified in the data element *Episode of treatment for alcohol and other drugs – treatment type (main), code N*.

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

National reporting requirements

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.

Implementation start date: 01/07/2013

Implementation end date: 30/06/2015

Comments: *Glossary items*

Glossary terms that are relevant to this national minimum data set are included here.

Cessation of treatment episode for alcohol and other drugs

Source and reference attributes

Submitting organisation: National Health Information Group

Relational attributes

Related metadata references: Supersedes Alcohol and other drug treatment services NMDS 2012-13 Health, Superseded 07/02/2013

Has been superseded by Alcohol and other drug treatment services NMDS 2015- Health, Standardisation pending 04/09/2014

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Statistical linkage key 581 cluster	Mandatory	1
-	Australian postcode (address)	Mandatory	1
-	Client type (alcohol and other drug treatment services)	Mandatory	1
-	Country of birth	Mandatory	1
-	Date of birth	Mandatory	1
-	Date of cessation of treatment episode for alcohol and other drugs	Mandatory	1
-	Date of commencement of treatment episode for alcohol and other drugs	Mandatory	1
-	Establishment identifier	Mandatory	1
-	Indigenous status	Mandatory	1
-	Injecting drug use status	Conditional	1
-	Main treatment type for alcohol and other drugs	Mandatory	1
-	Method of use for principal drug of concern	Conditional	1
-	Other drug of concern	Conditional	4
-	Other treatment type for alcohol and other drugs	Mandatory	4
-	Person identifier	Mandatory	1
-	Preferred language	Mandatory	1
-	Principal drug of concern	Conditional	1
-	Reason for cessation of treatment episode for alcohol and other drugs	Mandatory	1
-	Sex	Mandatory	1
-	Source of referral to alcohol and other drug treatment service	Mandatory	1
-	Statistical area level 2 (SA2)	Mandatory	1
-	Treatment delivery setting for alcohol and other drugs	Mandatory	1

Elective surgery waiting times (census data) NMDS 2013-

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	520140
Registration status:	Health, Standard 02/05/2013
DSS type:	National Minimum Data Set (NMDS)
Scope:	The scope of this national minimum data set (NMDS) is patients on waiting lists for elective surgery, as defined in the Elective care waiting list episode—elective care type, code N data element (also known as 'Waiting list category'), 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 waiting lists managed by hospitals operated by the Australian Defence Force, corrections authorities and Australia's external territories are not currently included. 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' and patients who are 'not ready for care', as defined in the Elective surgery waiting list episode—patient listing status, readiness for care code N data element.

Collection and usage attributes

Statistical unit:	Patients on waiting lists on census dates.
Collection methods:	Elective care waiting list episode—category reassignment date, DDMMYYYY is not required for reporting to the NMDS, but is necessary for the derivation of Elective surgery waiting list episode—waiting time (at a census date), total days N[NNN]. Elective care waiting list episode—elective care type, code N is not required for reporting to the NMDS, but is 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* Census dates are 30 September, 31 December, 31 March and 30 June.
Implementation start date:	30/09/2013

Comments:

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

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.

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

Source and reference attributes

Submitting organisation: National Health Information Management Group

Relational attributes

Related metadata references:

See also Elective care waiting list episode—elective care type, code N Health, Standard 02/05/2013

Supersedes Elective surgery waiting times (census data) NMDS 2012-13 Health, Superseded 02/05/2013

See also National Partnership Agreement on Improving Public Hospital Services: National Elective Surgery Target (Part 1) Health, Standard 21/11/2013

See also National Partnership Agreement on Improving Public Hospital Services: National Elective Surgery Target (Part 2) Health, Standard 21/11/2013

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Census date	Mandatory	1
-	Clinical urgency	Mandatory	1
-	Establishment identifier	Mandatory	1
-	Indicator procedure	Mandatory	1
-	Indigenous status	Mandatory	1
-	Listing date for care	Mandatory	1
-	Overdue patient	Mandatory	1
-	Patient listing status	Mandatory	1
-	Surgical specialty	Mandatory	1
-	Waiting time at a census date	Mandatory	1

Elective surgery waiting times (removals data) NMDS 2013-

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	520154
Registration status:	Health, Standard 02/05/2013
DSS type:	National Minimum Data Set (NMDS)
Scope:	The scope of this national minimum data set is patients removed from waiting lists for elective surgery (as defined in Elective care waiting list episode—elective care type, code N) 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 Elective care waiting list episode—elective care type, code N), but this is not part of the National Minimum Data Set (NMDS) for elective surgery waiting times. Patients removed from waiting lists managed by hospitals operated by the Australian Defence Force, corrections authorities and Australia's external territories are not currently included. 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.

Collection and usage attributes

Statistical unit:	Patients removed from waiting lists (for admission or other reason) during each financial year.
Collection methods:	Elective care waiting list episode—category reassignment date, DDMMYYYY is not required for reporting to the NMDS, but is necessary for the derivation of Elective surgery waiting list episode—waiting time (at removal), total days N[NNN]. Elective care waiting list episode—elective care type, code N is not required for reporting to the NMDS, but is 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.
Implementation start date:	01/07/2013
Comments:	There are two different types of data collected for this national minimum data set (census data and removals data) and the scope and list of data elements associated with each is different. 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.

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

Source and reference attributes

Submitting organisation: Department of Health and Ageing

Relational attributes

Related metadata references: See also Elective care waiting list episode—elective care type, code N Health, Standard 02/05/2013

Supersedes Elective surgery waiting times (removals data) NMDS 2012-13 Health, Superseded 02/05/2013

See also National Partnership Agreement on Improving Public Hospital Services: National Elective Surgery Target (Part 1) Health, Standard 21/11/2013

See also National Partnership Agreement on Improving Public Hospital Services: National Elective Surgery Target (Part 2) Health, Standard 21/11/2013

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Clinical urgency	Mandatory	1
-	Establishment identifier	Mandatory	1
-	Indicator procedure	Mandatory	1
-	Indigenous status	Mandatory	1
-	Listing date for care	Mandatory	1
-	Overdue patient	Conditional	1
-	Reason for removal from elective surgery waiting list	Mandatory	1
-	Removal date	Mandatory	1
-	Surgical specialty	Mandatory	1
-	Waiting time at removal from elective surgery waiting list	Mandatory	1

Public dental waiting times NMDS 2013-

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 494562

Registration status: Health, Standard 09/11/2012

DSS type: National Minimum Data Set (NMDS)

Scope: The purpose of the Public dental waiting times national minimum data set (PDWT NMDS) is to describe the information that must be collected to calculate the waiting times for two time periods in the treatment pathway for public dental services in Australia:

- The time between the date a person is placed on a waiting list and the date they are offered dental care; and
- The time between the date a person is placed on a waiting list and the date they receive dental care.

In this data collection, person includes all persons eligible for their state or territory public dental scheme, who were aged 18 years or over when they were placed on a general or prosthetic public dentistry waiting list for the purpose of receiving treatment.

The data collection includes:

- all people specified above with a *listing date for dental care* within the collection period
- all people specified above with a *date of offer of dental care* within the collection period
- all people specified above with a *date of first dental visit* within the collection period.

The data collection excludes:

- people who access their local public clinic but pay full price and are not eligible for their state or territory's public dental service
- people who are treated under jurisdictional priority client schemes.

In this data collection, treatment means any event consisting of the provision of dental care resulting from a person being placed on a public dental waiting list and funded under a public dental scheme of their state or territory. Only treatments received after a person is placed on a public dental waiting list should be recorded.

Excluded treatments are:

- treatment paid for in full by the person receiving the treatment
- treatment provided by practitioners funded from outside of the public dental health sector, e.g. treatment provided by General Medical Practitioners (GPs)
- treatments which do not result in removal from a waiting list, such as:

relief of pain that does not satisfy other dental treatment needs

emergency treatment that does not satisfy other dental treatment needs

where a person is on a general care or denture care waiting list, consultations to determine future care that do not result in the removal from the list

A public dental waiting list episode ends:

- at the *date of offer of dental care*, if this is the last recorded date; or
- at the *date of first dental visit.*

All dental services funded by the state or territory government should be included unless otherwise noted.

Collection and usage attributes

Statistical unit:	A public dental waiting list episode.
Collection methods:	This is an administrative collection and information is derived from client records. The collection period is the twelve month financial year, i.e. the twelve months ending 30 June.
Implementation start date:	01/07/2013

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare National Oral Health Plan Monitoring Group
Steward:	Australian Institute of Health and Welfare
Reference documents:	National Advisory Committee on Oral Health 2004. Healthy mouths healthy lives: Australia's national oral health plan 2004-2013. Viewed 31 January 2012, http://www.adelaide.edu.au/oral-health-promotion/resources/public/pdf_files/oralhealthplan.pdf

Relational attributes

Related metadata references:	Supersedes Public dental waiting times DSS 2012-13 Health, Superseded 09/11/2012

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
1	Date of birth	Mandatory	1
2	Sex	Mandatory	1
3	Australian postcode (address)	Mandatory	1
4	Area of usual residence (SA2)	Mandatory	1
5	Australian state/territory identifier (person)	Mandatory	1
6	Country of birth	Mandatory	1
7	Indigenous status	Mandatory	1
8	Preferred language	Mandatory	1
9	Public dental listing date	Mandatory	1

10	Public dental waiting list type	Mandatory	1
11	Offer of dental care date	Conditional	1
12	Date of first dental visit	Conditional	1

Data set specifications

Acute coronary syndrome (clinical) DSS 2013-

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	523140
Registration status:	Health, Standard 02/05/2013
DSS type:	Data Set Specification (DSS)
Scope:	The Acute coronary syndrome (ACS) data set specification is not mandated for collection but is recommended as best practice if ACS data are to be collected. This data set specification enables individual hospitals or health service areas to develop collection methods and policies appropriate for their service. The scope for the ACS data set specification is to collect data on the period between when a person with ACS symptoms was first referred to a hospital or directly presented at a hospital, and when a person leaves the hospital, either from the emergency department or is discharged from the hospital. Some of the data relevant to the management of patients attending hospital with ACS symptoms is specified for collection at follow-up visits with a specialist or as a non-admitted patient. 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 this data set specification are designed to underpin the data collected by health professionals in their day-to-day acute care practice. They relate to the realities of an acute clinical consultation 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 the ACS data set specification 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.

The ACS data set specification is 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 presented in the National Heart Foundation of Australia/Cardiac Society of Australia and New Zealand Guidelines for the management of acute coronary syndromes (MJA 2006;184;S1-S32). 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.

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

Where appropriate, it may be useful if the data definitions in this data set specification were also 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 the ACS data set specification), with that collected through other means (e.g. public health surveys, reports).

A set of 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 (Heart Foundation) and the Cardiac Society of Australia and New Zealand (CSANZ) initiative was diverse and included representation from the following organisations: the Heart Foundation, the CSANZ, the Australasian College of Emergency Medicine, the Australian Institute of Health and Welfare, the Australasian Society of Cardiac & Thoracic Surgeons, Royal Australian College of Physicians (RACP), RACP - Towards a Safer Culture, National Centre for Classification in Health (Brisbane), the NSW Aboriginal Health & 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 specification, 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 and usage attributes

Guide for use:

There are six data clusters in the Acute coronary syndrome (clinical) DSS. To ensure a complete description of the clinical management of acute coronary syndromes (ACS), it is recommended that all data clusters be collected along with the individual data elements during the current ACS event by the individual hospital or health service area.

The six data clusters in this DSS include:

1. Acute coronary syndrome clinical event cluster
2. Functional stress test cluster
3. Electrocardiogram cluster
4. Ventricular ejection fraction cluster
5. Acute coronary syndrome pharmacotherapy cluster
6. Coronary artery cluster

Collection methods:

The Acute coronary syndrome data set specification 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 specification 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.

Implementation start date:

01/07/2013

Relational attributes

Related metadata references:

Supersedes Acute coronary syndrome (clinical) DSS Health, Superseded 02/05/2013

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Acute coronary syndrome clinical event cluster	Conditional	1
-	Acute coronary syndrome pharmacotherapy data cluster	Optional	1
-	Coronary artery cluster	Optional	1
-	Electrocardiogram cluster	Optional	1
-	Functional stress test cluster	Optional	1
-	Ventricular ejection fraction cluster	Conditional	1
-	Acute coronary syndrome procedure type	Optional	1
-	Acute coronary syndrome related medical history	Optional	1
-	Acute coronary syndrome stratum	Optional	1
-	Admission date	Optional	1
-	Admission time	Optional	1
-	Angina status	Optional	1
-	Bleeding episode using TIMI criteria (status)	Optional	1
-	C-reactive protein level (measured)	Optional	1

-	Chest pain pattern category	Optional	1
-	Cholesterol—HDL (measured)	Optional	1
-	Cholesterol—LDL (calculated)	Conditional	1
-	Cholesterol—total (measured)	Optional	1
-	Clinical evidence of acute coronary syndrome related medical history	Optional	1
-	Clinical procedure timing (status)	Optional	1
-	Country of birth	Optional	1
-	Creatine kinase isoenzyme—upper limit of normal range (U/L)	Optional	1
-	Creatine kinase level (U/L)	Conditional	1
-	Creatine kinase MB isoenzyme level (micrograms per litre)	Conditional	1
-	Creatine kinase MB isoenzyme level (units per litre)	Conditional	1
-	Creatine kinase MB isoenzyme—upper limit of normal range (micrograms per litre)	Conditional	1
-	Creatine kinase MB isoenzyme—upper limit of normal range (units per litre)	Conditional	1
-	Creatinine serum level (measured)	Conditional	1
-	Date C-reactive protein level measured	Optional	1
-	Date creatine kinase MB isoenzyme measured	Conditional	1
-	Date creatinine serum level measured	Conditional	1
-	Date of birth	Optional	1
-	Date of death	Optional	1
-	Date of diagnostic cardiac catheterisation	Conditional	1
-	Date of implantable cardiac defibrillator procedure	Optional	1
-	Date of intra-aortic balloon pump procedure	Conditional	1
-	Date of most recent stroke	Conditional	1
-	Date of non-invasive ventilation administration	Conditional	1
-	Date of onset of acute coronary syndrome symptoms	Optional	1
-	Date of pacemaker insertion	Optional	1
-	Date of referral to rehabilitation	Optional	1
-	Date of triage	Optional	1
-	Date patient presents	Optional	1
-	Date troponin measured	Optional	1
-	Diabetes status	Conditional	1
-	Diabetes therapy type	Conditional	1
-	Dyslipidaemia treatment indicator	Conditional	1
-	Emergency department arrival mode - transport	Optional	1
-	Establishment identifier	Optional	1
-	Funding source for hospital patient	Optional	1
-	Glycosylated haemoglobin level (measured)	Optional	1
-	Glycosylated haemoglobin—upper limit of normal range (percentage)	Conditional	1

-	Height (measured)	Conditional	1
-	Hypertension - treatment	Optional	1
-	Indigenous status	Optional	1
-	Instrumented bleeding location	Optional	1
-	Killip classification code	Optional	1
-	Lifestyle counselling type	Optional	1
-	Mode of separation	Optional	1
-	Non-instrumented bleeding location	Optional	1
-	Number of episodes of angina in last 24 hours	Conditional	1
-	Other/Underlying cause of acute coronary syndrome	Optional	1
-	Person identifier	Optional	1
-	Premature cardiovascular disease family history (status)	Optional	1
-	Principal diagnosis—episode of care	Optional	1
-	Reason for readmission—acute coronary syndrome	Optional	1
-	Separation date	Optional	1
-	Sex	Optional	1
-	Time C-reactive protein level measured	Optional	1
-	Time creatine kinase MB isoenzyme measured	Conditional	1
-	Time of diagnostic cardiac catheterisation	Conditional	1
-	Time of implantable cardiac defibrillator procedure	Optional	1
-	Time of intra-aortic balloon pump procedure	Conditional	1
-	Time of non-invasive ventilation administration	Optional	1
-	Time of onset of acute coronary syndrome symptoms	Optional	1
-	Time of pacemaker insertion	Conditional	1
-	Time of triage	Optional	1
-	Time patient presents	Optional	1
-	Time troponin measured	Optional	1
-	Tobacco smoking status	Optional	1
-	Total blood units transfused	Conditional	1
-	Triage category	Conditional	1
-	Triglyceride level (measured)	Optional	1
-	Troponin assay type	Optional	1
-	Troponin assay—upper limit of normal range (micrograms per litre)	Conditional	1
-	Troponin level (measured)	Optional	1
-	Type of visit to emergency department	Optional	1
-	Underlying cause of death	Optional	1
-	Vascular history	Conditional	1
-	Weight in kilograms (measured)	Conditional	1

Breast cancer (cancer registries) DSS

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	491771
Registration status:	Health, Standard 01/09/2012
DSS type:	Data Set Specification (DSS)
Scope:	This breast cancer data set is not mandated for collection but is recommended as best practice if breast cancer data are to be collected. The data set would allow common, consistent and high quality breast cancer data to be collected by State and Territory cancer registries and collated nationally. This data will help inform research, policy, planning and guideline development work in the breast cancer area. Breast cancer may be used as a forerunner for other cancers in terms of establishing common data collections across cancer registries. This data set includes 20 items, with the inclusion of five new standards and the addition of further detail to several existing standards.

Collection and usage attributes

Guide for use:	Report each of the data elements in this data set once, and in no particular order.
Collection methods:	State and Territory cancer registries collect data on incidence and annually report data to the Australian Institute of Health and Welfare.

Source and reference attributes

Submitting organisation:	National Breast and Ovarian Cancer centre (NBOCC) Australasian Association of Cancer Registries (AACR) Australian Institute of Health and Welfare (AIHW)
Steward:	Australasian Association of Cancer Registries (AACR)
Origin:	National Breast and Ovarian Cancer centre (NBOCC) Australasian Association of Cancer Registries (AACR) Australian Institute of Health and Welfare (AIHW)
Reference documents:	Johnson CH, Adamo M (eds.), SEER Program Coding and Staging Manual 2007. National Cancer Institute, NIH Publication number 07-5581, Bethesda, MD 2007.

Relational attributes

Related metadata references:	Supersedes Breast cancer (Cancer registries) DSS Health, Superseded 01/09/2012

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*

-	Cancer staging—M stage code	Mandatory	1
-	Cancer staging—N stage code	Mandatory	1
-	Cancer staging—T stage code	Mandatory	1
-	Cancer staging—TNM stage grouping code	Mandatory	1
-	Date of diagnosis of cancer	Mandatory	1
-	Histopathological grade	Mandatory	1
-	Human epidermal growth factor receptor-2 test result	Mandatory	1
-	Human epidermal growth factor receptor-2 test type	Mandatory	1
-	Laterality of primary cancer	Mandatory	1
-	Lymphovascular invasion	Mandatory	1
-	Morphology of cancer	Mandatory	1
-	Most valid basis of diagnosis of cancer	Mandatory	1
-	Neo-adjuvant therapy	Mandatory	1
-	Number of positive sentinel lymph nodes	Mandatory	1
-	Number of regional lymph nodes examined	Mandatory	1
-	Number of sentinel lymph nodes examined	Mandatory	1
-	Oestrogen receptor assay result	Mandatory	1
-	Primary site of cancer (ICD-O-3 code)	Mandatory	1
-	Regional lymph nodes positive	Mandatory	1
-	Tumour size at diagnosis (solid tumours)	Mandatory	1

Cardiovascular disease (clinical) DSS

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 470731

Registration status: Health, Standard 01/09/2012

DSS type: Data Set Specification (DSS)

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 and usage attributes

Collection methods: 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.

Implementation start date: 01/09/2012

Relational attributes

Related metadata references: Supersedes Cardiovascular disease (clinical) DSS Health, Superseded 01/09/2012

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Alcohol consumption frequency (self reported)	Mandatory	1
-	Alcohol consumption in standard drinks per day (self reported)	Mandatory	1
-	Australian postcode (address)	Mandatory	1
-	Behaviour-related risk factor intervention	Mandatory	8
-	Behaviour-related risk factor intervention - purpose	Mandatory	5
-	Blood pressure—diastolic (measured)	Mandatory	1
-	Blood pressure—systolic (measured)	Mandatory	1
-	Cholesterol—HDL (measured)	Mandatory	1
-	Cholesterol—LDL (calculated)	Mandatory	1
-	Cholesterol—total (measured)	Mandatory	1
-	Country of birth	Mandatory	1
-	Creatinine serum level (measured)	Mandatory	1
-	CVD drug therapy—condition	Mandatory	1
-	Date of birth	Mandatory	1
-	Date of diagnosis	Mandatory	1
-	Date of referral to rehabilitation	Conditional	1
-	Diabetes status	Mandatory	1
-	Diabetes therapy type	Mandatory	1
-	Division of General Practice number	Mandatory	1
-	Fasting status	Mandatory	1
-	Formal community support access status	Mandatory	1
-	Height (measured)	Mandatory	1
-	Indigenous status	Mandatory	1
-	Informal carer existence indicator	Mandatory	1
-	Labour force status	Mandatory	1
-	Living arrangement	Mandatory	1
-	Person identifier	Mandatory	1
-	Physical activity sufficiency status	Mandatory	1
-	Preferred language	Mandatory	1
-	Premature cardiovascular disease family history (status)	Mandatory	1
-	Proteinuria status	Mandatory	1
-	Renal disease therapy	Mandatory	1
-	Service contact date	Mandatory	1
-	Sex	Mandatory	1
-	Tobacco smoking status	Mandatory	1

-	Tobacco smoking—consumption/quantity (cigarettes)	Mandatory	1
-	Triglyceride level (measured)	Mandatory	1
-	Vascular history	Mandatory	1
-	Vascular procedures	Mandatory	1
-	Waist circumference (measured)	Mandatory	1
-	Weight in kilograms (measured)	Mandatory	1

Injury surveillance DSS 2013-

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	516747
Registration status:	Health, Standard 02/05/2013
DSS type:	Data Set Specification (DSS)
Scope:	The scope of this minimum data set is patient level data from selected emergency departments of hospitals and other settings.

Collection and usage attributes

Collection methods:	*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.
Implementation start date:	01/07/2013

Source and reference attributes

Submitting organisation:	National Health Information Group

Relational attributes

Related metadata references:	Supersedes Injury surveillance DSS 2010-13 Health, Superseded 02/05/2013

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Activity when injured	Mandatory	1
-	Activity when injured (non-admitted patient)	Mandatory	1
-	Bodily location of main injury	Mandatory	1
-	External cause	Mandatory	99
-	External cause—human intent	Mandatory	1
-	Narrative description of injury event	Mandatory	1
-	Nature of main injury (non-admitted patient)	Mandatory	1
-	Place of occurrence of external cause of injury (ICD-10-AM)	Mandatory	1
-	Place of occurrence of external cause of injury (non-admitted patient)	Mandatory	1

Surveillance of healthcare associated infection: *Staphylococcus aureus* bacteraemia DSS

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METeOR identifier:	391133
Registration status:	Health, Standard 15/11/2012
DSS type:	Data Set Specification (DSS)
Scope:	The purpose of this data set specification (DSS) is to support a comprehensive surveillance program of healthcare associated infections (HAI). HAIs are those infections that are not present or incubating at the time of admission to a healthcare program or facility, develop within a healthcare organisation or are produced by micro-organisms acquired during admission. This DSS is intended to support *Staphylococcus aureus* bacteraemia (SAB) surveillance in Australian hospitals. It is designed for the purposes of HAI surveillance, not diagnosis. The value of surveillance as part of a hospital infection control program is supported by high-grade international and national evidence. This DSS supports development of local forms and systems for surveillance of HAIs and associated data collection. This DSS applies to patient episodes of SAB in Australian hospitals. **Case Definition – Healthcare associated *Staphylococcus aureus* bacteraemia (SAB)** A patient-episode of *Staphylococcus aureus* bacteraemia (SAB) is a positive blood culture for *Staphylococcus aureus*. For surveillance purposes, only the first isolate per patient is counted, unless at least 14 days has passed without a positive culture, after which an additional episode is recorded. A SAB will be considered to be a healthcare-associated event if: EITHER • CRITERION A. The patient's first SAB positive blood culture was collected more than 48 hours after hospital admission or less than 48 hours after discharge. OR • CRITERION B. The patient's first positive SAB blood culture was collected less than or equal to 48 hours after hospital admission and one or more of the following key clinical criteria was met for the patient-episode of SAB: 7. SAB is a complication of the presence of an indwelling medical device (e.g. intravascular line, haemodialysis vascular access, CSF shunt, urinary catheter) 8. SAB occurs within 30 days of a surgical procedure where the SAB is related to the surgical site 9. SAB was diagnosed within 48 hours of a related invasive instrumentation or incision 10. SAB is associated with neutropenia (Neutrophils: less than 1 x 10^9/L) contributed to by cytotoxic therapy

In order for jurisdictions and private hospital ownership groups to accurately report and monitor Healthcare Associated Infections, the data elements listed should be collected at hospital level for each patient-episode of *Staphylococcus aureus* bacteraemia. HAI patient episode data elements for SAB, by short name

Data elements to be collected for each patient episode	**Data elements used for calculation of SAB rates**
Person identifier	Patient days
Family name	Patient episodes of healthcare associated SAB
Given name(s)	
Indigenous status	
Date of birth	
Sex	
Address line (person)	
Suburb/town/locality name (person)	
Australian state/territory identifier	
Australian postcode (address)	
Admission date	
Separation date	
Ward/clinical area	
Specimen collection date	
Specimen collection time	
Laboratory number	
Specimen identifier	
Laboratory result identifier	
Healthcare associated SAB clinical criteria	
Staphylococcus aureus bacteraemia status	
SAB methicillin susceptibility	
Antibiotic susceptibility (MRSA isolate)	
Antibiotic susceptibility indicator (MRSA isolate)	
Establishment number	

Collection and usage attributes

Statistical unit:	Episodes of infection (*Staphylococcus aureus* bacteraemia (SAB))
Guide for use:	Surveillance data should be used to identify local problem areas and implement appropriate policy and clinical interventions to improve the quality of care, not for external benchmarking. Effective surveillance systems provide the impetus for change and make it possible to evaluate the effectiveness of interventions. An effective surveillance system is one that provides timely and reliable information to hospital managers and clinicians to effectively manage HAI.
Comments:	Surveillance is an important tool to reduce HAI. The purpose of collecting, analysing, and then acting on reliable surveillance data is to improve quality and patient safety within a service or facility or jurisdiction.

Source and reference attributes

Submitting organisation:	Australian Commission on Safety and Quality in Health Care (ACSQHC)
Origin:	ACSQHC Healthcare Associated Infection Advisory Committee's Technical Working Group

Relational attributes

Related metadata references:	See also Surveillance of healthcare associated infection: Clostridium difficile infection DSS Health, Standardisation pending 23/07/2012

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
1	Person identifier	Optional	1
2	Family name	Optional	1
3	Given name(s)	Optional	1
4	Indigenous status	Optional	1
5	Date of birth	Optional	1
6	Sex	Optional	1
7	Address line (person)	Optional	1
8	Suburb/town/locality name within address	Optional	1
9	Australian state/territory identifier (person)	Optional	1
10	Australian postcode (address)	Optional	1
11	Admission date	Optional	1
12	Separation date	Optional	1
13	Ward/clinical area	Optional	1
14	Specimen collection date	Optional	1
15	Specimen collection time	Optional	1
16	Laboratory number	Optional	1
17	Specimen identifier	Optional	1

18	Laboratory result identifier	Optional	1
19	Healthcare associated *Staphylococcus aureus* bacteraemia clinical criteria	Optional	1
20	*Staphylococcus aureus* bacteraemia status	Conditional	1
21	*Staphylococcus aureus* bacteraemia methicillin susceptibility indicator	Conditional	1
22	Antibiotic susceptibility (Methicillin-resistant *Staphylococcus aureus* isolate)	Conditional	8
23	Antibiotic susceptibility indicator (Methicillin-resistant *Staphylococcus aureus* isolate)	Conditional	8
24	Patient days	Mandatory	1
25	Patient episodes of healthcare associated *Staphylococcus aureus* bacteraemia	Mandatory	1
26	Establishment number	Mandatory	1

Classification schemes

Australian Classification of Health Interventions (ACHI) 8th edition

Identifying and definitional attributes

Metadata item type:	Classification Scheme
Synonymous names:	ACHI 8th edn
METeOR identifier:	514008
Registration status:	Health, Standard 02/05/2013 Tasmanian Health, Final 01/07/2014
Definition:	The National Centre for Classification in Health classification of health interventions.
Classification structure:	ACHI is comprised of: • Tabular List of Interventions - contains a seven character code, in the format NNNNN-NN. Generally, the first five characters represent the Medical Benefits Schedule (MBS) item number and the last two characters are allocated for each procedural concept derived from the MBS item description. Two appendices are specified: Mapping table; and ACHI codes listed in numerical order. • Alphabetic Index of Interventions - an alphabetic index to the ACHI Tabular List of Interventions that contains many more procedural terms than those appearing in the ACHI Tabular List.

Source and reference attributes

Origin:	National Casemix and Classification Centre (NCCC) 2012. The Australian Classification of Health Interventions (ACHI) – Eighth Edition - Tabular list of interventions and Alphabetic index of interventions. Wollongong: NCCC, Australian Health Services Research Institute, University of Wollongong.
Revision status:	ACHI was developed by the National Centre for Classification in Health (NCCH) at the University of Sydney. During the development, the NCCH was advised by members of the NCCH Coding Standards Advisory Committee (CSAC) and the Clinical Classification and Coding Groups (CCCG), consisting of expert clinical coders and clinicians nominated by the Clinical Casemix Committee of Australia. In 2010, the National Casemix and Classification Centre (NCCC) at the University of Wollongong assumed responsibility for ACHI development and maintenance. NCCC developed the 2012 version of ACHI, released for implementation in 2013. In 2013, the NCCH at the University of Sydney once again assumed responsibility for ACHI development and maintenance, as part of a consortium under the name of the Australian Centre

for Classification Development (ACCD). The ACCD comprises the NCCH, the University of Western Sydney and KPMG.

From 1 July 2014, all ICD-10-AM/ACHI/ACS and AR-DRG related products are available for purchase from the Independent Hospital Pricing Authority (IHPA). For further information, contact the IHPA via the following email address:

classification.licensing@ihpa.gov.au

Relational attributes

Related metadata references:	Supersedes Australian Classification of Health Interventions (ACHI) 7th edition Health, Superseded 02/05/2013
Value Domains based on this Classification Scheme:	Elective care type code N Health, Standard 02/05/2013 Indicator procedure code NN Health, Standard 02/05/2013 Procedure code (ACHI 8th edn) NNNNN-NN Health, Standard 02/05/2013 Tasmanian Health, Final 01/07/2014

Australian Refined Diagnosis Related Groups version 6

Identifying and definitional attributes

Metadata item type:	Classification Scheme
Synonymous names:	AR-DRG v 6
METeOR identifier:	391288
Registration status:	Health, Standard 30/06/2013
Definition:	The Commonwealth Department of Health and Ageing classification for the reasons for hospitalisation and the complexity of cases that a hospital treats.

Collection and usage attributes

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

Relational attributes

Related metadata references:	Supersedes Australian Refined Diagnosis Related Groups version 5.1 Health, Superseded 22/12/2009 Has been superseded by Australian Refined Diagnosis Related Groups version 7 Health, Standardisation pending 30/06/2013
Value Domains based on this Classification Scheme:	Diagnosis related group code (AR-DRG v 6) ANNA Health, Standard 30/06/2013 Major diagnostic category code (AR-DRG v 6) NN Health, Standard 30/06/2013

International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 8th edition

Identifying and definitional attributes

Metadata item type:	Classification Scheme
Synonymous names:	ICD-10-AM 8th edn
METeOR identifier:	514003
Registration status:	Community Services, Standard 10/04/2013 Health, Standard 02/05/2013 Tasmanian Health, Final 30/06/2014
Definition:	The National Centre for Classification in Health classification of diseases and related health problems.
Classification structure:	ICD-10-AM is comprised of: • Tabular List of Diseases - contains core three character codes with some expansion to four and five character codes. Two appendices are specified: Morphology of neoplasms; and Special tabulation lists for mortality and morbidity. • Alphabetic Index of Diseases - consists of three sections: Section I is the index of diseases, syndromes, pathological conditions, injuries, signs, symptoms, problems and other reasons for contact with health services. Section II is the index of external causes of injury. The terms included here are not medical diagnoses but descriptions of the circumstances in which the violence occurred. Section III is the index of drugs and other chemical substances giving rise to poisoning or other adverse effects (also known as the Table of drugs and chemicals).

Source and reference attributes

Origin:	National Centre for Classification in Health (NCCH) 2010. The International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) – Seventh Edition - Tabular list of diseases and Alphabetic index of diseases. Sydney: NCCH, Faculty of Health Sciences, The University of Sydney.
Revision status:	ICD-10-AM was developed by the National Centre for Classification in Health (NCCH). During the development, the NCCH was advised by members of the NCCH Coding Standards Advisory Committee (CSAC) and the Clinical Classification and Coding Groups (CCCG), consisting of expert clinical coders and clinicians nominated by the Clinical Casemix Committee of Australia.

Relational attributes

Related metadata references:	Supersedes International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition Health, Superseded 02/05/2013

Value Domains based on this Classification Scheme:	Activity type code (ICD-10-AM 8th edn) ANNNN Health, Standard 02/05/2013 Diagnosis code (ICD-10-AM 8th edn) ANN{.N[N]} Community Services, Standard 10/04/2013 Health, Standard 02/05/2013 Tasmanian Health, Final 30/06/2014 External cause code (ICD-10-AM 8th edn) ANN{.N[N]} Health, Standard 02/05/2013 Place of occurrence (ICD-10-AM 8th edn) ANN{.N[N]} Health, Standard 02/05/2013 Primary site of cancer code (ICD-10-AM 8th edn) ANN{.N[N]} Health, Standardisation pending 13/03/2013

Urgency Related Group classification (version 1.3)

Identifying and definitional attributes

Metadata item type: Classification Scheme

Synonymous names: URG

METeOR identifier: 501472

Registration status: Health, Standard 07/02/2013
Independent Hospital Pricing Authority, Standard 31/10/2012

Definition: A classification for the reasons for patient attendance at an **emergency department** and the complexity of cases that an emergency department treats.

Classification structure: Episodes of care are grouped initially on the basis of episode end status (also known as 'disposition'):

- Admitted
- Non-admitted
- Did not wait

Within the disposition categories of admitted and non-admitted, episodes are grouped further based on the urgency of a patient's need for care (as reported by triage category) and the patient's diagnosis. For example:

- Admitted
  - Triage 1
    - All major diagnostic blocks
  - Triage 2
    - Alcohol/drug abuse
    - Musculoskeletal/connective tissue illness
    - Circulatory system/respiratory system illness
    - Injury
    - Poisoning
    - All other major diagnostic blocks

Source and reference attributes

Origin: Independent Hospital Pricing Authority 2012. Independent Hospital Pricing Authority, Sydney. Viewed 2 October 2012, <http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/ABF-Price-Model-Reference-Classifications-for-2012-13>

Relational attributes

Related metadata references: Supersedes Urgency related group version 1.2 Independent Hospital Pricing Authority, Superseded 30/10/2012

Value Domains based on this Classification Scheme: Urgency Related Group (v1.3) code [X]N[N] Health, Standard 07/02/2013
Independent Hospital Pricing Authority, Standard 31/10/2012

Glossary items

Activity based funding

Identifying and definitional attributes

Metadata item type:	Glossary Item
Synonymous names:	ABF
METeOR identifier:	496325
Registration status:	Health, Standard 07/02/2013 Independent Hospital Pricing Authority, Standard 31/10/2012
Definition:	A method of funding health services based on amount and type of activity.
Context:	Activity based funding in the context of health is a method of funding hospitals and health services whereby health services are funded for the provision of patient care based on the type and mix of patients they treat. A set amount is paid to the health service based on the relative cost of the group to which the patient is classified.

Collection and usage attributes

Guide for use:	Activity based funding has three essential elements: Classification: Allocation of patients treated into groups which allow weightings to be applied. The groups should have resource use homogeneity (patients within a group should cost a similar amount to treat) and be clinically coherent (patients within a group should be clinically similar). Activity data: Counting the patients treated. Cost data: Determining the cost of treatment.

Source and reference attributes

Submitting organisation:	Independent Hospital Pricing Authority
Reference documents:	Battista P, Brophy J 2011. Casemix for Beginners. Proceedings of the National Casemix and Activity Based Funding Conference 2011. Viewed 25 September 2012, http://casemixconference2011.com.au/proceedings

Relational attributes

Metadata items which use this glossary item:	Activity based funding: Admitted acute hospital care DSS 2013-2014 Independent Hospital Pricing Authority, Superseded 01/03/2013 Activity based funding: Admitted sub-acute and non-acute hospital care DSS 2013-2014 Independent Hospital Pricing Authority, Standard 11/10/2012 Activity based funding: Emergency department care DSS 2013-2014 Independent Hospital Pricing Authority, Superseded

01/03/2013

Activity based funding: Emergency service care DSS 2013-2014 Independent Hospital Pricing Authority, Standard 31/10/2012

Activity based funding: Emergency service care DSS 2014-2015 Health, Proposed 02/01/2014
Independent Hospital Pricing Authority, Candidate 02/01/2014

Activity based funding: Non-admitted patient care aggregate DSS 2013-2014 Independent Hospital Pricing Authority, Superseded 01/03/2013

Activity based funding: Non-admitted patient care DSS 2013-2014 Independent Hospital Pricing Authority, Superseded 01/03/2013

Admitted subacute and non-acute hospital care DSS 2014-15 Health, Standard 11/04/2014

Hospital teaching and training activities DSS 2014-15 Health, Standard 07/03/2014

Independent Hospital Pricing Authority funding designation code N Health, Standard 11/04/2014

Non-admitted patient care aggregate NMDS 2013-14 Health, Superseded 11/04/2014

Non-admitted patient DSS 2013-14 Health, Superseded 07/03/2014

Non-admitted patient DSS 2014-15 Health, Standard 07/03/2014

Anaesthesia

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	504029
Registration status:	Health, Standard 07/02/2013
Definition:	A technique used to introduce an agent to produce a state of reduced or absence of sensation to the woman for the operative or instrumental delivery of the baby.
Context:	Perinatal statistics

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	See also Analgesia Health, Standard 07/02/2013
Metadata items which use this glossary item:	Birth event—anaesthesia administered indicator Health, Standard 07/02/2013 Birth event—anaesthesia administered indicator, yes/no code N Health, Standard 07/02/2013 Birth event—type of anaesthesia administered Health, Standard 07/02/2013 Birth event—type of anaesthesia administered, code N[N] Health, Standard 07/02/2013 Perinatal DSS 2014-15 Health, Standard 07/03/2014 Perinatal NMDS 2013-14 Health, Superseded 07/03/2014 Perinatal NMDS 2014- Health, Standard 07/03/2014 Type of birth anaesthesia administered code N[N] Health, Standard 07/02/2013

Analgesia

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	504043
Registration status:	Health, Standard 07/02/2013
Definition:	An analgesic agent or technique administered to the woman to relieve the pain of labour without causing loss of consciousness.
Context:	Perinatal statistics

Source and reference attributes

Submitting organisation:	National Perinatal Data Development Committee

Relational attributes

Related metadata references:	See also Anaesthesia Health, Standard 07/02/2013
Metadata items which use this glossary item:	Birth event—analgesia administered indicator Health, Standard 07/02/2013 Birth event—analgesia administered indicator, yes/no code N Health, Standard 07/02/2013 Birth event—type of analgesia administered Health, Standard 07/02/2013 Birth event—type of analgesia administered, code N[N] Health, Standard 07/02/2013 Perinatal DSS 2014-15 Health, Standard 07/03/2014 Perinatal NMDS 2013-14 Health, Superseded 07/03/2014 Perinatal NMDS 2014- Health, Standard 07/03/2014 Type of labour analgesia administered code N[N] Health, Standard 07/02/2013

Local Hospital Network

Identifying and definitional attributes

Metadata item type:	Glossary Item
Synonymous names:	LHN
METeOR identifier:	491016
Registration status:	Health, Standard 07/02/2013
Definition:	One of a number of separate legal entities established by each Australian state/territory government in order to devolve operational management for public hospitals, and accountability for local service delivery, to the local level. Local Hospital Networks (LHNs) directly manage single or small groups of public hospital services and their budgets, and are directly responsible for hospital performance under the Performance and Accountability Framework outlined in Schedule D of the National Health Reform Agreement 2012. Most LHNs are responsible for the provision of public hospital services in a defined geographical area, but in some jurisdictions a small number of LHNs provide services across a number of areas. Some jurisdictions have their own local names for the areas and administrative units known nationally as Local Hospital Networks. For example, in New South Wales they are known as 'Local Health Districts', in Queensland they are known as 'Hospital and Health Services', in South Australia they are known as 'Local Health Networks', and in Tasmania they are known as 'Tasmanian Health Organisations'.

Source and reference attributes

Reference documents:	The National Health Reform Agreement 2012: Council of Australian Governments, Canberra. Viewed 20 December 2012, http://www.federalfinancialrelations.gov.au/content/npa/health_reform/national-agreement.pdf

Relational attributes

Metadata items which use this glossary item:	Establishment—Local Hospital Network identifier Health, Standard 07/03/2014 Establishment—Local Hospital Network identifier, code NNN Health, Standard 07/03/2014 Establishment—Local Hospital Network identifier, code NNN Health, Candidate 29/08/2014 Hospital—Local Hospital Network identifier Health, Standard 07/02/2013 Hospital—Local Hospital Network identifier, code NNN Health, Superseded 07/03/2014 Local Hospital Network identifier Health, Standard 07/02/2013 Local Hospital Network identifier code NNN Health, Standard

07/03/2014

Local Hospital Network identifier code NNN Health, Candidate 29/08/2014

Local Hospital Network identifier code NNN Health, Superseded 07/03/2014

Local Hospital Networks DSS 2014-15 Health, Standard 11/04/2014

Medicare Local National Health Performance Authority, Standard 28/11/2013

Medicare Local identifier National Health Performance Authority, Standard 28/11/2013

Non-admitted patient care Local Hospital Network aggregate DSS 2014-15 Health, Standard 11/04/2014

Non-admitted patient DSS 2014-15 Health, Standard 07/03/2014

Urgency related groups

Identifying and definitional attributes

Metadata item type:	Glossary Item
Synonymous names:	URGs
METeOR identifier:	496744
Registration status:	Health, Standard 07/02/2013 Independent Hospital Pricing Authority, Standard 31/10/2012
Definition:	A patient classification scheme which provides a means of relating the number and types of patients treated in an **emergency department**.
Context:	Urgency related groups (URGs) provide a summary of the complexity and type of patients treated within an emergency department. Emergency department episodes of care are grouped into URGs based on: • The disposition recorded at the end of the patient's emergency department stay. This is captured by the episode end status. • The urgency of the patient's need for care. This is captured by the triage category. • The nature of the patient's diagnosis. This is captured by the major diagnostic block.

Source and reference attributes

Submitting organisation:	Independent Hospital Pricing Authority

Relational attributes

Metadata items which use this glossary item:	Activity based funding: Emergency department care DSS 2013-2014 Independent Hospital Pricing Authority, Superseded 01/03/2013 Emergency department stay—urgency related group major diagnostic block, code N[AA] Health, Standard 11/04/2014 Emergency department stay—urgency related group major diagnostic block, code N[AA] Health, Superseded 11/04/2014 Independent Hospital Pricing Authority, Standard 31/10/2012 Non-admitted patient emergency department care DSS 2014-15 Health, Standard 11/04/2014 Non-admitted patient emergency department care NMDS 2013-14 Health, Superseded 11/04/2014 Non-admitted patient emergency department care NMDS 2014-15 Health, Standard 11/04/2014 Urgency related group major diagnostic block Health, Standard 07/02/2013 Independent Hospital Pricing Authority, Standard 30/10/2012

4 Data elements listed by technical name

List of tables

Related publications

This publication, *National Health Data Dictionary: version 16.1*, is one of the last of a regular series. Earlier versions can be downloaded for free from the AIHW via the METeOR website <http://meteor.aihw.gov.au/content/index.phtml/itemId/274816>.

The following AIHW publications relating to data development, health information and other national data dictionaries might also be of interest:

- Australian Institute of Health and Welfare (AIHW) 2014. Creating nationally-consistent health information: engaging with the national health information committees. Cat. no. CSI 18. Canberra: AIHW.
- AIHW 2014. National Community Services Data Dictionary: version 8. Cat. no. HWI 126. Canberra: AIHW.
- AIHW 2013. National Housing and Homelessness Data Dictionary: version 1. Cat. no. HOU 269. Canberra: AIHW.
- AIHW 2007. A guide to data development. Cat. no. HWI 94. Canberra: AIHW.

The National Health Data Dictionary (NHDD) provides national data standards for the health sector. This version (Version 16.1) reflects changes to data standards between May 2012 and the end of June 2013. Six national minimum data sets, 5 data set specifications, 61 data elements, 4 classification schemes and 5 glossary items have been added to the NHDD. Eighteen national minimum data sets, 15 data set specifications, 89 data elements, 6 classification schemes and 5 glossary items have been superseded or retired since the previous version of the NHDD (Version 16) was published.